SHIP Navigation Guide

Other Information

Book 4

LOCAL HELP FOR PEOPLE WITH MEDICARE

Medicare Eligibility - Under 65 and Disabled

You qualify for Medicare if you are under 65, disabled, and:

You have been entitled to Social Security or Railroad Retirement Act Disability benefits for **24 months**, making you eligible for Medicare coverage in the 25th month.

You have been diagnosed as having **End Stage Renal Disease (ESRD)**, permanent kidney failure, need regular dialysis, or have had a kidney transplant and are receiving Social Security disability benefits. You will be eligible for Medicare after 3 months of dialysis.

You have been diagnosed as having **Lou Gehrig's disease (ALS)**, and are receiving disability benefits. You will be eligible for Medicare immediately.

Enrolling in Medicare

Enrollment in Medicare is automatic once you have met the eligibility requirements. Your Medicare card should arrive approximately 3 months prior to the date Medicare is scheduled to begin. You will be enrolled in both Medicare parts A and B. You can refuse part B by contacting your local Social Security Office.

Medicare Costs

For most beneficiaries Medicare Part A is premium free. There is a monthly premium for Part B. This premium is based on the beneficiary's annual income. According Medicare, 70% of beneficiaries in 2016 fall under the "held-harmless" rule and will pay a premium of $104.90. For new beneficiaries, those not collecting Social Security and dual eligible individuals, the 2016 premium will be $121.80. Also, Medicare beneficiaries with higher annual incomes pay a higher Part B premium based on their annual income. In addition to the monthly premium, you will be responsible for the deductibles, co-pays, and coinsurance associated with Medicare.

Medicare Options

Medicare Supplement Insurance (Medigap)

Medicare Supplement Insurance plans, also known as Medigap plans, are private insurance policies that are specifically designed to fill the “gaps” in Medicare. These gaps include deductibles, co-pays, and coinsurance. In Indiana there are 14 standardized policies, A through N, (10 currently approved for current sales in Indiana).

In 2016, no companies in Indiana offer Medigap plans to individuals who are under 65 and disabled.

When you become age 65, you will then have a 6 month enrollment period when you will have a **guaranteed issue** for any Medigap plan offered in Indiana. During this time insurance companies cannot charge you a higher premium or impose a waiting period because of your disability or health history. (See Navigation Guide 2 Medicare Supplemental Insurance, Section F for more information on Medigap plans).

SHIP has a package of information that includes a list of companies that offer Medigap plans. This package of information includes Centers for Medicare and Medicaid Services’ (CMS) Choosing a Medigap Policy.

Medicare Advantage Plans

Medicare offers beneficiaries the option to receive care through private Insurance plans. These private insurance options have been known as Medicare+Choice plans, and are not called Medicare Advantage Plans.

Private insurance companies' contract with CMS to manage your health care and to provide your Medicare approved services. **The most common type of Medicare Advantage plans are health maintenance organizations (HMOs), preferred provider plans (PPO's), and private-fee-for-service (PFFSs)**.

You have the same rights to enroll in an Advantage Plan as those who receive Medicare due to age. There are **no waiting periods** for pre-existing conditions, and the plan must enroll you unless you have ESRD or the plan is at enrollment capacity.

To enroll, you must live in an area that is served by the Advantage Plan. There are two types of service areas, local and regional. Local service areas cover specific counties and or zip codes. In order to enroll in these plans you must live in the specified area. Regional service areas offer coverage on a much larger scale, often state-wide or multi-state coverage. Indiana is in the same region as Kentucky. Any Medicare beneficiary that lives in Indiana, regardless of county or zip code, may enroll in a regional plan.

A list of plans is available from the SHIP website at www.medicare.in.gov as well as, the Medicare website: www.medicare.gov.

Medicare and Employer Plans

If you have Medicare and you are covered by an employer large group Health plan, (sponsored by an employer/employee organization of 100+workers), the employer plan will provide your primary coverage. Medicare will be secondary as long as the covered employee is **covered under active employment**. Otherwise, Medicare is primary.

Medicare and Medicaid

Full Medicaid Benefits

Medicaid is a joint federal and state program that helps pay your medical costs if you have limited income and have limited assets. If you qualify for both Medicare and Medicaid, most of your medical costs will be covered. Medicaid may also pay for some services that are not covered by Medicare such as nursing home care. The income and asset limits to qualify for Medicaid are:

2015

	INCOME	**ASSETS**
SINGLE	$981/MONTH	$2,000
COUPLE	$1,328/MONTH	$3,000

For a couple with dependents, additional income of $337 per dependent may be allowed. A $20.00 monthly income disregard is not included in the figures listed above.

Medicare Savings Program (MSP)

If your income or assets are above the limits to qualify for full Medicaid, you may still be able to qualify for the Medicare Savings Program. This program is set up to assist qualified Medicare beneficiaries is paying their Part B Premium, and or Medicare deductibles and copays/coinsurance. Those eligible for SLMB and QI receive assistance in paying for their monthly Part B premium only.

If you believe that you may qualify for full Medicaid, and/or QMB/SLMB/QI, you will need to contact your local Department of Family Resources.

2015

		Income Limit	Asset Limit
QMB Qualified Medicare Beneficiary	SINGLE	$1,491	$7,280
	COUPLES	$2,021	$10,930
SLMB Specified Low Income Medicare Beneficiary	SINGLE	$1,688	$7,280
	COUPLES	$2,278	$10,930
QI Qualified Individual	SINGLE	$1,835	$7,280
	COUPLES	$2,477	$10,930

COBRA

Consolidated Omnibus Reconciliation Act-1985

COBRA is a **temporary extension** of your employer's group health insurance coverage. You must **apply within 60** days of a specific qualifying event or you will lose your right to extend your group coverage under COBRA. The employer must notify the plan's administrator within 30 days of the qualifying event. The plan administrator must send you a COBRA election notice within 14 days of receiving notification. To sign up you should talk to the employer's benefits or human services division. **COBRA can help you if you are under 65 and disabled and qualify as you may find it difficult to buy other health care insurance.**

The employee and their dependent beneficiaries **must be offered the same health insurance benefits** with the same deductibles and benefit limits that they were receiving before the COBRA qualifying event.

You are eligible if:

- The employer has 20 or more employees.
- The employee has worked at least half of the working days in the previous year.
- The employee is covered by the group health plan and you are in the employer group plan on the day before the employee has a "qualifying event". (A specific event that causes you to lose employer group health care coverage).

Qualifying Event	Who is Eligible	Length of Eligibility
Voluntary or involuntary termination of employment/reduction of work hours Other than for "gross misconduct"	Employee Spouse Dependent Child	18 Months
Employee enrolls in Medicare Part A or B	Spouse Dependent Child	36 Months
Employee & covered individual divorce	Spouse Dependent Child	36 Months
Employee dies	Spouse Dependent Child	36 Months

Loss of dependent child status	Dependent Child	36 Months

Under COBRA you will be paying the entire premium for coverage plus a 2% administrative charge. While this can be expensive, **compare the total cost and benefits** of COBRA coverage with the total cost and benefits of other options. (including Original Medicare, Medicare Advantage Plans, Medigap policies, and private health care insurance) to determine what will best suit your finances and health needs. Be sure to compare:

- Prescription coverage
- Eye, dental, foot, and other coverage
- Maximum benefits limits (annual & specific types of care)
- Co-pay amounts
- Yearly deductibles

COBRA and Social Security Disability Benefits

The employer group health insurance extends for 18, 29, or 36 months, (depending on the qualifying event). If you qualify for Social Security disability benefits, special rules apply to extend the 18 months of COBRA coverage to **29 months**. To receive this special coverage extension, you must notify the former employer insurance division with 60 days of receiving your disability determination.

You pay the entire premium, plus a 2% administrative charge to the continued group health plan for the first 18 months. If your disability started before COBRA, your group coverage will be extended to 29 months and for the last 11 months your premium will be 150%. If you enroll in Medicare A or B after already being on COBRA your COBRA will end.

SPECIAL NOTE: If you have Medicare prior to the qualifying event, you must be offered COBRA coverage.

For more information about COBRA, call the SHIP State Office and ask for a COBRA brochure, or call the Department of Labor for COBRA information at 1-202-219-8784 or 1-202-219-8776. To learn more about how to apply for Social

Security or Medicare benefits, call 1-800-772-1213 (for hearing impaired, TTY: 1-800+325-0778) or visit www.ssa.gov.

Medicare and Permanent Kidney

Failure-End Stage Renal disease (ESRD)

Medicare & ESRD

- You must require dialysis or a kidney transplant.
- You can enroll in Medicare for coverage through the Social Security Administration.
- If you are able to get Medicare because of kidney failure, Medicare coverage starts the 3rd month after dialysis begins.
- Medicare coverage ends 12 months after dialysis stops.
- Medicare ends 36 months after a successful kidney transplant.

Medicare Advantage Plans and ESRD

Medicare Advantage Plans **cannot** enroll ESRD Medicare beneficiaries. If you are already in an Advantage Plan and develop ESRD, then the plan must continue to provide coverage.

ESRD and Employer Group Health Plans (EGHP)

Employer group health plans will pay first, for a **coordination period** of 30 months, beginning the month you are eligible for Medicare. If the group plan pays all health expenses, you may want to wait until the end of the 30 month period to enroll in Medicare. Delaying enrollment means that you will not be paying the Part B monthly premium. However, your Part B premium will be increased by 10% for each year you delay enrollment.

If you are in a group health plan and leave employment, you can continue the group health coverage by taking your COBRA option.

Under COBRA you will be paying the entire premium for coverage plus a 2% administrative charge. If you do not elect COBRA when you are eligible, then enrolling in Medicare could be your only option for health insurance coverage.

Medicare Part B ESRD Coverage

Medicare will cover dialysis treatment at any approved dialysis facility including the cost of equipment, supplies, lab tests, and other services.

Special Note:

- If you do not enroll in Medicare Part B at the time that you first become eligible, you will have to wait for the General Enrollment Period (Jan, Feb, or Mar). Medicare part B coverage would not become effective until July.
- If you do not elect COBRA coverage, you will not have a guaranteed issue for a Medigap policy.

For further information about Medicare and ESRD:

Medicare Coverage of Kidney Dialysis and Kidney Transplant Services-a supplement to your Medicare Handbook

(CMS publication #CMSS10128)

The Renal Network to be called only **regarding quality of care complaints** in a dialysis facility, and not for information about Medicare coverage. **1-317-257-8265**

National Government Services for information about ESRD coverage.

1-800-622-4792 or online at: www.medicare.gov

The Indiana Department of Insurance

- Does **Not Sell Insurance.** Insurance agencies and agents sell policies that are developed by private insurance companies.
- Provides consumer service to help with complaints against and information about various insurance agencies and insurance agents.
- Supervises the organization, regulation, examination, rehabilitation, liquidation, and conservation of all insurance companies residing in (domiciled) or authorized to do business in Indiana When a company is licensed to do business in Indiana, it is issued a "Certificate of Authority" by the Department of Insurance.
- Enforces, administers, and executes the insurance laws of Indiana. It also regulates insurance agents' licensing requirements.
- Regulates Individual Accident and Health Insurance policies-both policy forms and rates. Group Accident and Health policies have only the policy forms regulated, not rates.
-

Policies Purchased Outside of Indiana

A policy is regulated by the state in which it is purchased. Regulation varies from state to state and with different types of insurance.

Example: You have a policy from another state and move to Indiana. Your policy will still provide all stated benefits and is still regulated by the state in which it was purchased. Insurance companies may sell policies in many states and must comply with the regulation of each state.
Counselors should refer persons to the Department of Insurance in the state in which the policy was purchased. For further information, refer to the "Guide to Health Insurance for People with Medicare".
(Counselors, please note that 800#s may be usable only within a particular state.)

Individual vs. Group Policies

Individual Policies

As when insuring a home or automobile, you contract directly with an insurance company and receive a policy. You become the **policyholder**.

- The company needs approval from the Department of Insurance to change the policyholder's premiums. Any rate increase affects the entire class of policyholders. Insurance companies define what they mean by class (i.e. all Indiana policyholders, policyholders in the 46260 Zip Code, etc.)
- The company cannot cancel your policy because of your health or claims as long as the premiums are paid on time.

Group Policies

Group insurance may offer lower premiums by having a large number of beneficiaries in one group, thereby spreading the insurance company's risks. The insurance policy is for the group and is called the "**master policy**". The employer or trade association is the "master policyholder".

The **master policyholder** can do any of the following:

- Reduce or change the benefits and coverage
- Increase your share of the premium
- Switch to another insurance company
- Drop the insurance coverage completely
- The insurance contract (the policy) is between the Group and the insurance company, not the individual. The Group should have the master policy available for review by you or anyone within the Group.

When you buy insurance coverage under this Group, you are issued a "Certificate of insurance", and you become a "certificate holder". This certifies that you are a member of the Group and are entitled to insurance benefits under the Group's policy. Instead of a policy, certificate holders receive a summary of benefits or a

benefits handbook. The master policy is the contract; the hand book is only a summery and is not binding on the insurance company.

Parts to a Policy

A.O.S.P.R.

- **A**pplication
- **O**utline of Coverage – overview of the policy, plan description
- **S**chedule of Benefits – specifics of the policy (cost, daily benefit, maximum benefit, individual policy number, benefits purchased)
- **P**olicy
- **R**iders (if applicable)

Policy Form Number

All policy forms are assigned a **policy form number**. This number is found on the bottom left corner of the cover of the policy. The Outline of Coverage has a different number. You may need to give the policy form number when talking with your insurance company or Department of Insurance regarding questions about a specific policy.

Important Concepts of health Insurance Policies

Underwriting - Are You Insurable?

- **Insurance companies are for-profit businesses**. Therefore, they will underwrite to determine their risks if they sell you a policy. The company is trying to predict the likelihood that you will become sick or injured and as a result file claims.
- **Each company has its own underwriting standards**. One company may reject your application while another might accept it.
- **Companies need to verify your answers to question on insurance application forms**. When you sign an application, you give the insurance company permission to receive confidential information about your health from your doctors or other service providers.

Underwriting Factors

Age – With advancing age comes more frequent illnesses. For this reason, insurance companies usually charge higher premiums, and you may have a harder time buying insurance.

Health – Your current health status and past history of illnesses may cause insurance companies to reject your application, charge an increased premium, or to exclude certain conditions from coverage. Be sure to consider any "guaranteed issues" that you may have.

Occupation – Persons with hazardous jobs may find it difficult to by insurance. Office or school workers will have less trouble buying insurance than a test pilot or a race car driver.

Habits and Lifestyle – Habits such as smoking or drinking can result in expensive health problems. Companies may either charge higher rates or deny you coverage.

A policy may be cancelled or claims not paid if it is found that incomplete or incorrect information was given on the application.

Guaranteed Issue Policies

- Some policies are sold without medical underwriting (without health questions of the application). These policies are **sold to anyone who applies and is qualified**. Hospital indemnity and specific disease policies are often guaranteed issue. (See Other Health Insurance) Some companies sell **guaranteed issue Medicare Supplement** policies.
- **Pre-existing Condition.**
- **Definition:** Any medical condition for which you receive treatment, advice, or medication prior to obtaining insurance coverage.
- When medical conditions are listed on the application, there is usually a waiting period during which time benefits are not paid. Some policies may not cover any preexisting conditions.

Usual, Customary, and Reasonable – UCR

Most insurance companies have their own fee schedule listing the usual, customary and reasonable (UCR) and do not use the actual bills to calculate the amount they will pay. (Similar to Medicare's fee schedule and the Medicare approved amount).

The UCR is the amount the company believes to be a fair price for the medical services and is often less than the doctor's actual bill. If a policy promises to pay 80% of approved medical expenses, that means it will pay 80% of the UCR.

UCR Ex:	Medical bills	$2,000
	Company's UCR	$1,500
	Company pays 80%	$1,200
	Person's co-payment	$800
	(20% of the UCR + excess charges up to actual cost)	

Coordination of Benefits

- If you are covered under 2 different group health insurance plans, the total benefits paid for the same service by both plans will be adjusted so that payment does not go above the UCR.
- One plan will be "primary", the other "secondary" the primary plan will provide its normal benefits. The secondary plan may pay all or a portion of the difference between what the primary plan pays and the UCR.

Renewing Policies

- **Term** – the policy terminates at the end of a set period of time and cannot be renewed.
- **Cancelable** – the policy can be cancelled by the company at any time.
- **Optionally Renewable** – the policy can be cancelled at the company's option.

- **Conditionally Renewable** – There are strings attached. Ex: the policy can be cancelled by the company when you reach age 65.
- **Guaranteed Renewable –** You may renew the policy every year or at the stated time interval. The policy is renewed as long as the premiums are paid. Premiums can be raised, but only on a class basis (for everyone in a pre-set group) Ex: The insurance company can't single you out by raising your rates just because you are getting older or because you are having a lot of claims. **All Medigap and most LTC insurance policies are this type**.
- **Non-cancelable** – The policy cannot be cancelled for any reason except for nonpayment of premiums or misrepresentation on the application and under this provision the company **may not raise premiums for any reason.**

Rate Regulation

Companies that sell individual insurance policies in Indiana must file their rates with the Department of Insurance.

How does an insurance company get a rate increase? The company files a proposal for new rates on specific individual policies, showing its anticipated income and expenses on those policies. The Department uses rate experts known as "actuaries" who consider the company's statistics on income and expenses and its predictions of future claims and expenses.

What are Indiana's legal requirements on rates? Indiana law states, "rates are to be reasonable, adequate, and not unfairly discriminatory". This means that when companies set rates they can only take into account factors such as age, sex, and area of residence if the company can prove that these factors contribute to higher risks.

What is a loss ratio? The loss ratio shows what portion of the total premiums the company collects is actually paid out on customers' claims. Loss ratios apply only to claims. Companies also have administrative expenses.

How often can an insurance company request a rate increase? As often as the company thinks it is necessary. Companies seldom submit more than one rate request per year. Companies must show they will continue to lose money over time at the current rate charged.

What can you do if you can't afford the premiums? Shop around. The present company may have a more affordable policy, (with fewer benefits and lower premiums), or another company may be able to match the present benefits but at a lower price.

Guaranty Association

Indiana law formed the Indiana Life and Health Insurance Guaranty Association to protect policy owners in the event of a life or health insurance company becoming insolvent, (unable to pay debts or becomes bankrupt).

Responsibilities of the Guaranty Association

- To pay unpaid claims that is a result of insolvency.
- To assure policy owners that their policy will continue as long as the premiums are paid, and as long as the maximum benefits as stated in the policy or of the Guaranty Association have not been reached.

All companies writing life and health insurance in Indiana belong to the Indiana Life and Health Guaranty Association. All states, the District of Columbia, and Puerto Rico have Guaranty Associations.

When the state of Indiana determines that an insurance company is insolvent, the mechanism that springs into action to protect policyholders is called the "State Guaranty Association System". This system operates in all states, the District of Columbia, and Puerto Rico.

The total liability of the Indiana Guaranty Association may not exceed a total of $300,000 for all benefits on any one person, and $100,000 in cash value on any one person.

The Guaranty Association is intended to be a form of consumer protection, not an inducement in the solicitation of insurance.

How to Check On An

Insurance Company Before Buying

Complaint Statistics

One way to compare insurance companies is the Complaint Index Ratio. This ratio shows consumer complaints filed with the Department of Insurance in 2015 compared with premiums received by insurance companies. A Complaint Index Ratio is available for Health Carriers, Life, Auto, and Homeowners. For detailed information, call the Indiana Department of Insurance-Consumer services.

1-800-622-4461 or www.in.gov.idoi

Insurance Rating Reports

These reports are done by **Financial Rating Service** companies that print yearly reports on most insurance company financial stability. You may call the service directly, or look up its report in the local public library. Always check at least 2 rating services. Each rating service has its own rating system (which will be explained in the front of each report).

These reports also state the types of insurance sold by a company, whether the company once operated under a different name, and the company's invested assets. Companies usually invest their money in stocks, bonds, mortgages, and real estate. The total amount of assets is shown in thousands of dollars.

It's a good idea to see if the insurance company's rating has changed over the last couple of years.

Examples of the top rating for 3 of these sources are:

A.M. Best – A++ Moody's – AAA Standard U Poor's AAA

See your SHIP Telephone Reference for telephone numbers of these rating services.

How to Return an Insurance Policy

Most health policies have a 10-day free look, except for Medicare Supplement and Long Term Care Insurance, which have a 30-day free look. A “free look” means that you have the right to look over your policy and return it within the time limit for a full refund. (If your policy was mailed to you, keep the envelope as proof of the date that it was sent).

You may exercise your right to return a policy either by sending it to the insurance company by certified mail and asking for a return receipt, or to your agent who will give you a receipt.

IF A POLICY SEEMS TOO GOOD TO BE TRUE

IT PROBABLY IS!

Method of Paying Premiums

You may be able to save some money by the way you pay your insurance premiums. The more divided the premium payments are, the more interest the insurance companies charge. Typically, the interest charges are:

Quarterly 5% Monthly 6% Annual 0% Semiannual 2%

If you pay monthly by automatic transfer of funds (where the bank automatically withdraws money from your account and pays the insurance company), the interest charge usually ranges from 0% to 2%. This may mean a savings of 4%-6% monthly. The agent may ask for a blank check to begin the automatic withdrawal of premiums. (Make sure to write "VOID" on the check).

Storing Insurance Policies

- Store all insurance policies together.
- Keep a list of the insurance companies, type of policy, and specific policy numbers. (A copy of this list should be given to a trusted relative or friend).
- Original policies should not be kept in the bank's safe-deposit box, only copies. In the event of an accident or death you may not have access to the safety-deposit box.

Introduction to Medicaid

Established in 1965, Medicaid is a state and federally funded health care program designed to assist low income individuals and families. In order to qualify for Medicaid assistance the individual/family must meet certain eligibility requirements. The Medicaid program is administered on the state level. As a result, some requirements and rules vary from state to state.

In Indiana, Medicaid is administered through the Family and Social Services Administration (FSSA) by the Department of Family Resources (DFR). Changes to the Medicaid program come from the Indiana General Assembly as well as the Center for Medicare and Medicaid Services (CMS).

Medicaid Covered Services

Medicaid can help pay for the following types of medical services.

- Physician services
- Hospital Inpatient and Outpatient care and Rural Clinic services
- Other clinic, laboratory, and x-ray services
- Nursing facility services – Skilled and intermediate care, and intermediate care for the mentally retarded.
- Dental
- Optometric services including eyeglasses and prosthetics devices
- Podiatry services
- Chiropractic services
- Hospice services
- Home health care services
- Care coordination services for pregnant women, persons with HIV/AIDS, and persons who are seriously mentally ill/emotionally disturbed
- Any other medical or remedial care recognized under Indiana law and specified by federal regulation

- Prescription drugs

Medicaid Services (cont'd)

- Medical supplies and equipment
- Skilled Nursing Home (NH) care
- Transportation to Medicaid covered services
- Nurse midwife services
- Family planning
- Health screening follow-up services for children
- Physical, occupational, speech, and respiratory therapy
- Preventive care including screening, diagnosis, or necessary treatment for all medical recipients under age twenty-one

Qualifying for Medicaid

In Indiana the Department of Family Resources (DFR) determines

Eligibility and need for Medicaid services. Eligibility for singles, couples, and households is determined by a combination of factors that includes: medical needs, income and asset levels (refer to O-page 3) for income and asset figures). To apply for Medicaid, you must contact your Department of Family Resources. The DFR must rule on your application within 45 days, or 90 days if you are applying because of a disability.

Indiana Medicaid Non-financial Eligibility Requirements

- You must be a resident of the State of Indiana.
- You must be a US citizen or a non-citizen of eligible immigration status.
- Lawful immigrants, who enter the United States after August 22, 1966 are eligible for full Medicaid coverage for 5 years.
    - During this time period legal immigrants can receive emergency medical care if they meet the other Medicaid requirements.

- Immigrants with proof of legal residence can receive emergency medical care if they meet other Medicaid requirements.
- You must also demonstrate a medical need to be eligible for Medicaid.

In addition to the residency and medical need requirements, you must also meet one of the following categories:

- Individuals who are age 65 or older
- Blind
- Disabled

***Note**: Even through you are receiving SSI disability benefits you must still meet the income requirements of DFR.*

- Refugees.
- Low-income families with dependent children. Recipients of Temporary Assistance for Needy Families (TSNF) may be eligible in this category.
- Children under age 19 and individuals age 28,19, and 20 who have special living conditions such as being institutionalized, or living in a family with an income at or below the Federal Poverty Level (FPL).
- Pregnant women and newborns up to age 1, if born to women who are receiving Medicaid.

Indiana Medicaid Financial Eligibility Requirements

Financial eligibility is based on your (and your spouse's) income and assets. If the application is for a child the income and assets of their parents are included in determining eligibility.

Medicaid 2015

	INCOME	**ASSETS**
SINGLE	$981	$2,000
COUPLE	$1,328	$3,000

The above amounts are subject to change each year based on Cost of Living Allowances (COLA) and (FPL) when new levels are announced. SSA's Extra Help income limits do not affect beneficiaries who are deemed eligible even though their incomes are above SSA's Extra Help limits.

When applying for Medicaid, you should have your medical records, doctor's statements of medical needs, statements of income, and information on you assets.

Checklist of Documents you will need for Medicaid

- Records showing age and place of birth, baptismal record
- Social Security number, Medicare claim number, Railroad Retirement number, Veterans claim number
- Record of marriage
- Property deeds on property which you own but in which you do not live
- Burial trust or pre-paid funeral arrangements
- All life and medical insurance policies (for life insurance you will need a written verification from the company of the current cash surrender value of the policy)
- Documentation of all property transferred within the past five years.
- Records of your income and the income of spouse and dependent children in the home.
- Social Security benefits: the check or letter notification if within 12 months. You can request verification from SSA
- Veterans benefits: the check or letter notification if within `12 months
- Railroad Retirement benefits, the check or letter notification if within 12 months
- Unemployment compensation
- Retirement or Union benefits: the check or letter notification if within 12 months
- Income from rental property

- Earnings: name of employer, pay stubs, covering the last three months, verification or work expense
- Bank statements showing the balance in any and all accounts owned (checking, savings, CD's, Christmas Club, etc.) for each month for which coverage is sought
- Verification of ownership and current value of any stocks or bonds (includes U.S. Savings Bonds)
- Documents pertaining to any trust for which either applicant or spouse is the beneficiary or for which either is the trustee.
- Verification of the current market value of any non-motorized recreational vehicle, camper trailer, boat, etc. owned jointly or individually by applicant or spouse
- A listing of the contents of any safety deposit box rented by either spouse (further documentation may be required depending on the contents)
- A signed statement of the amount of cash both spouses currently have on hand.
- Description and verification of the current value of any other available resources not listed.

All are from list provided by the Senior Law Project

Assets Typically Counted by Medicaid:

- Cash
- Money in the bank, checking, savings etc.
- Stocks
- Bonds
- Cash surrender values of insurance policies

Eligibility depends on how many resources you own on the first day of any calendar month. You are then either eligible or ineligible for the rest of the month regardless of any resources changes during that month.

Exempted Assets

When applying for Medicaid, some assets are not counted and are therefore classified as being **"exempt"**. These assets may include:

- **Your Home**: Your home is exempt:
  - When it is the principal residence for the applicant, or for their spouse or children (if these children are under age 21, or are disabled or blind)
  - If a sibling with equity interest in the home resided in the home for at least one year prior to the patient's NH admission.
  - If a child was living in the home for at least 2 years prior to the NH admission with the purpose of providing needed care to the parent.
- L**ife Insurance Cash Surrender Values** are exempt if the death benefit (face value) of all policies, (excluding term life insurance) is $10,000 or less, and the beneficiary is one's estate or the funeral home. The $10,000 limit is reduced by any amount that is in an irrevocable funeral trust.
- **Burial for funeral trusts** are exempt if irrevocable, regardless of their value, as long as the trust money is tied to specific services.
- **Income producing property** is exempt if the income produced is greater than the expenses of ownership. The income from these properties may be considered by Medicaid. Other real estate that is in the name of the community spouse is exempt.
- **Household goods** such as furniture, appliances, etc., and personal items such as clothing are exempt.
- **One vehicle,** regardless of value is exempt if it is necessary for employment, medical treatment, or if you are disabled and the vehicle has been altered to accommodate your disability.

In determining Medicaid eligibility, **Supplemental Security (SSI)** does not count as income. **SSI** is Social Security income to people who are age 65 or older, or blind, or have a disability, and who have low incomes and little assets.

Medicaid Nursing Home Assistance

Prior to entering a nursing home, discuss whether the NH is a certified facility for Medicaid, and if there is a waiting list for beds.

To qualify for Medicaid nursing home assistance (NH) costs, you must meet the asset criteria. If you qualify, your income except for a personal needs allowance of $52/month will go towards paying for your care in the (NH). Medicaid would then pay for any medical costs over and above your income.

See "**Spousal Impoverishment"** brochure for income and asset protections for the spouse at home.

Your medical criteria is assessed by case managers to determine if you are able to receive assistance, and what level of medical care you may require. The preadmission screening (PAS) results also determine whether you need to be in a nursing home, or with the proper assistance you can stay at home. If you refuse the PAS, you will not be eligible for Medicaid assistance for one full year from the date that you are admitted into a nursing home.

An **Elder law** attorney who is knowledgeable about Medicaid may be of help with planning, application, and appeals. These services may be obtained at a reduced cost through the **Legal Services Organization**, the Senior Law Project, 1-800-869-0212, or through your local **Area Agency on Aging (AAA)**

Spousal Impoverishment Provision

The purpose of the Spousal Impoverishment amendment is to protect spouses of nursing home residents from losing all of their income and assets to pay for the NH spouse's care. The law allows the spouse living in the community to keep some assets and income and still be able to get Medicaid assistance for the NH spouse. Income and assets are each treated a little differently under the Spousal Impoverishment provision

Income

The couple's income falls into two categories: Personal and Jointly Owned.

1. **Personal Income:** Income in one's own name remains that person's personal income. Ex: checks made out in the wife's name would be considered her income.
2. **Jointly Owned Income:** Jointly owned income from dividends, interest, or jointly owned income is divided in half.

If you are the spouse at home, you may retain all of your personal income plus half of the jointly owned income. As the spouse at home, (community spouse) when your income is less than $1,991.25 per month, you may keep part of the income of your spouse who is in the nursing home in order to bring your income up to that amount. This standard increases annually.

The community spouse who needs more income to pay for mortgages, utilities, rent, etc. is able to appeal to Medicaid to keep more from what was to be paid to the nursing home. In order to appeal, the shelter expenses must be greater than $547 per month. The income limit is then $2,980.50 per month. Other dependent family members may also be able to keep some of the nursing home spouse's income. **For special needs, the community spouse may appeal to keep more money.**

For Example:

Let's look at Charles and Hazel. Hazel lives at home. Charles is entering the nursing home. Their combined monthly income is $2,325

	Charles (NH Spouse)	Hazel (At Home Spouse)	Joint
SS Checks	$900	$600	$0
Rental Property	$0	$0	$450
Charles IRA	$375	$0	$0

Charles has $1,500 in income (personal income plus1/2 jointly owned income). Hazel has $825 in income. Under the Spousal Impoverishment Provision, Hazel would be able to keep enough of Charles's income to bring her to the minimum standard of $1,991.25.

Assets

In determining the assets of a couple for the Spousal Impoverishment Provision, a **"Snapshot" Date** must be determined. The Snapshot Date is the first day of the first month a spouse is institutionalized for at least 30 days, or likely to be in a facility for at least 30 days. This date could be several years in the past. The

Snapshot is of the couple's assets on that date. The division of the assets is based on what the couple owned on the Snapshot Date. Details of the assets would need to be recreated for a Snapshot Date in the past.

For Example:

Let's go back to Charles and hazel. Hazel lives at home: Charles entered the nursing home May 15, 2013. The Snapshot Date for Charles and Hazel is May 2013 The division of Charles and Hazel's assets will be based on what they owned on may1, 2013.

Most assets are considered joint assets between husband and wife, (regardless of whose name they are in). The exception is real estate owned in one spouse's name. This real estate is considered personal property. The home and one car of any value are considered exempt assets, and are not counted in the division of assets. The Department of Family resources sets a budget for the community spouse. The community spouse is able to keep the highest of the following:

- Half of all countable assets up to a maximum limit of $119,220.
- A minimum of $23,844.

The nursing home spouse is allowed to keep $2,000 in assets. The at- home spouse's assets must be transferred into their name within 90 days, so that only the allowed remains in the nursing home spouse's name.

Transferring of Assets

When applying for Medicaid, Medicaid will look back over a period of time to see if there has been any transfer of assets for less than the fair market value of those assets. If assets have transferred (other than to a spouse), there may be a period of ineligibility for Medicaid assistance.

Transfers made are subject to a 36 month (or 3 year) look back period. **Trust** transfers are subject to a **60 month or 5 year look back period**.

The number of months of ineligibility is calculated by dividing the uncompensated value of the asset transferred by the average monthly cost of nursing home care.

The period of ineligibility begins when the asses is transferred. A partial calendar month is “rounded down” to the lower month (ex: 7.45 months is rounded to 7). If all assets transferred are returned then there is no penalty forgetting Medicaid assistance.

Transfers of property affect eligibility of only nursing home residents and persons who receive Home and Community-Based Services, (waivered services). Other applicants or recipients are not affected by transfers.

Paying Back Medicaid

Medicaid has a legal right to file claims to recover its costs from the estate of a deceased Medicaid beneficiary. This is called a **Preferred Claim**. The value of exempt resources may be recovered from your estate to cover the cost of any care and/or services that were provided and paid by Medicaid.

This is termed a **Preferred Lien**.

Supplemental Security Income (SSI)

SSI is a Federal Program that:

- Pays a monthly income to you if you are in financial need, aged 65+, blind, or disabled. You may receive both Social Security and SSI.
- Income, assets, and support from other sources will determine your SSI benefits.
- Exempted assets may differ from those used for Medicaid eligibility.

How is SSI Different from Social Security?

- Unlike Social Security, SSI is not based on your prior work experience or the work experience of a family member.
- SSI is financed through the general funds of the US Treasury, personal income taxes, corporate taxes, and other taxes. Social Security taxes (FICA-Federal Insurance Contribution Act) **do not fund** SSI benefits.
- You must be blind, disabled, or at least 65 years old, and have limited income and assets.

SSI - effective January 1, 2016

	INCOME BENEFIT RATE	**ASSETS**
SINGLE	**$733**	**$2,000**
COUPLE	**$1,100**	**$3,000**

To apply for SSI, contact the Social Security Administration

Medicare Savings Program (MSP)

Under the Medicare Savings Program (MSP) Medicare beneficiaries with low incomes and limited resources may be eligible to receive help in paying their Medicare costs. There are three categories of help available: QMB, SLMB, and QI.

QMB – Qualified Medicare Beneficiary

- For individuals up to 150% Federal Poverty Level (FPL)
- Helps pay for Part A and Part B premiums, deductibles, and co-insurance.

SLMB – Specified Low-Income Medicare Beneficiary

- Pays for Medicare Part B premium only.
- For individuals up to 170% Federal Poverty level (FPL)

QI - Qualified Individual

- Pays for Medicare Part B only**.**
- For individuals up to 185% Federal Poverty level (FPL)
- Must be recertified by Congress every one to two years and funding caps in place for the QI program.

To Apply for QMB, SLMB, or QI

If you feel that you may qualify for QMB, SLMB, or QI, contact your local Division of Family Resources. Contact Social Security Administration if you do not already have Medicare Part A

Normally when you qualify for a Medicare Savings Program, benefits will begin the month after the month in which approval occurred.

MEDICARE SAVINGS PROGRAM 2015

		INCOME	ASSETS
QMB Qualified Medicare Beneficiary	SINGLE	$1,491	$7,280
	COUPLES	$2,012	$10,930
SLMB Specified Low Income Medicare Beneficiary	SINGLE	$1,688	$7,280
	COUPLES	$2,278	$10,930
QI Qualified Individual	SINGLE	$1,835	$7,280
	COUPLES	$2,477	$10,930

- Figures for Medicare Savings Program change every spring.
- $20.00 income disregard is not included.
- You can have QMB/SLMB AND full Medicaid. QMB/SLMB will pay every month.

Losing Eligibility for Medicaid/QMB/SLMB

The cost-of-Living Adjustment (COLA) with Social Security (SS) retirement benefits occurs in January and increases your SS income; however, new income levels for Medicaid/QMB/SLMB/QI are effective in April. So, an increase in your SS income due to COLA may result in your getting a letter stating that you are no longer eligible for Medicaid/QMB/SLMB/QI. If you get a letter, contact your local

Medicaid office for an explanation.

MEDIGAP SUSPENSION WITH MEDICAID

You may ask your insurance company to suspend Medigap premiums, (benefits will therefore be suspended also), for a period of up to 24 months (if your Medigap policy was purchased after 11/91). This suspension will not result in a cancellation.

Suspension Requests

- You must make the request for a policy suspension to the insurance company that issued your Medigap policy within 90 days of your becoming eligible for Medicaid.
- The suspension may last up to 24 months if the policy was purchased after 11/91.
- During the suspension period the Medigap insurance company may not charge the policyholder for premiums and does not provide benefits.
- If Medicaid eligibility stops, the Medigap insurance company must reinstate the Medigap policy effective as of the date of losing Medicaid eligibility. You must notify the insurance company of the loss of Medicaid within 90 days of the loss.
- In some cases, Medicaid may pay your Medigap premiums.

It is possible for an individual to be receiving Medicare benefits, have a Medigap policy, and also be receiving Medicaid. In this instance, Medicare pays first, the Medigap policy pays second, and Medicaid pays third.

Alternatives to Nursing Home Care

OPTIONS – Your long term care solution

Indiana has waivers from the federal government which allows Medicaid in Indiana to offer alternatives to nursing home care. These alternatives are **In-Home Services and Community-type Care**. In the past, it was easier to be approved for Medicaid funding for nursing home care. Now through the Indiana Family and Social Services Administration (FSSA) Division of Aging, the Options program has been developed to promote a full range of long-term care options.

The idea behind OPTIONS is to have the funds follow the individual allowing them to choose their own care. These options include Assisted Living, Adult Day Care, and Adult Family Care.

Assisted Living

Assisted Living is a comprehensive, residential service provided thorough the Aged and Disabled Medicaid Waiver and the Assisted Living Medicaid Waiver. If you receive this service, you will reside in an **independent setting** provided by a licensed provider. Services include:

- Personal Care
- Homemaker Services
- Attendant Care
- Medication Oversight
- Social and Recreational programming

Adult Day Services

Adult Day Services is a comprehensive **non-residential service** provided through the Aged and Disabled Medicaid Waiver. Under this waiver, you will receive services in a community setting at a **minimum of 3 hours a day, and a maximum of 12 hours a day**. This service will allow you to live with family and allow your caregiver to maintain routine activities and responsibilities. Services include:

- Health, social, recreational and therapeutic activities
- Support Services

- Meal and /or snacks

Adult Family Care

Adult Family Care is a comprehensive, residential service provided through the Aged and Disabled Medicaid Waiver. If you receive services through this service, you will reside in a home with an unrelated primary caregiver and family. There may be up to two other consumers living at the residence as well. Services include:

- Personal Care
- Homemaker Service
- Attendant Care
- Companionship
- Medication Oversight
- Transportation
- Meals.

Eligibility for OPTIONS

You must be participating in the Medicaid Waiver, and these services must be an approved Individual Plan of Care. Eligibility depends on meeting the following requirements:

- Eighteen years of age or older
- Meet financial guidelines for Medicaid
- Nursing Facility level of care
- Have a Level of Service rating of 1, 2, or 3. If the Level of Service
- Rating is above a 3, the level of care needed is too high for the services provided.

The **Area on Aging (AAA)** administers the Waiver programs in addition to providing other community and in-home services. AAAs are responsible for individual assessments to determine medical needs. A case manager will be assigned to you. **The case manager will complete an assessment to determine hour eligibility as well as your Level of Service rating**. Case

managers will work with you, your family, physician, and other health works to make sure you are receiving the services that meet your needs.

For more information:

- www.LTCOPTIONS.in.gov
- Area Agency on Aging 1-800-986-3505
- FSSA Division of Aging 1-800-545-11—7763

Other Programs Administered by Area Agencies on Aging:

- Family Support Services
- Social Service Block Grant
- Title III – the Older Americans Act
- Other local and privately supported services
- Indiana Township Trustees:
- There are 1,008 townships in Indiana
- Call 1-888-482-4639 for locations or visit their website: www.indianatownshipassoc.org
- Indiana law requires that the Township Trustees provide essential services to the residents to quickly meet the needs of an individual in an emergency.
- Poor relief – health care assistance, utilities, housing, blood, and burial assistance when no other means of payment are available.

Community Health Centers

- Community Health Centers provide medical services to people on a sliding fee scale. For a complete listing of these centers in Indiana, refer to Section P of Navigation Guide #4

HIP 2.0 – Healthy Indiana Plan

HIP 2.0 program overview

The *NEW* Healthy Indiana Plan (or "HIP 2.0") is a health insurance program from the State of Indiana that pays for medical expenses and provides incentives for members to be more health conscious. HIP 2.0 provides coverage for qualified low-income Hoosiers who are interested in participating in a low-cost, consumer-driven health care program.

Who's eligible?

Indiana residents ages 19-64 with incomes of up to $16,297 annually for an individual, $21,967 for a couple or $33,307 for a family of four are generally eligible to participate in HIP 2.0.

What's covered?

There are two distinct levels of coverage in HIP 2.0: HIP Plus and HIP Basic. Each covers medical expenses such as doctor visits, hospital care, therapies, medications, prescriptions and medical equipment. HIP Plus offers members the best value and, unlike HIP Basic, also covers vision and dental care, and even bariatric surgery.

How does the POWER Account work?

In the HIP program, the first $2,500 of covered medical expenses is paid for out of a special savings account called a Personal Wellness and Responsibility (POWER) Account. The state will pay most of this amount, but members are also required to make a small contribution each month. These POWER Account contributions can be made by the member's employer or a not-for-profit organization. HIP members get to choose a health plan that will manage and track the POWER Account and collect the member's portion each month.

What are the contribution amounts?

Monthly POWER Account contributions are determined by income and will be approximately two percent of family income. Income ranges for eligible Hoosiers and a helpful calculator to help you estimate your monthly POWER Account contribution amount can be found online at HIP.IN.gov.

As long as members make their required monthly POWER Account contributions, they will have no other costs. The only exception to this is a charge of up to $25 if a member goes to a hospital emergency room for a non-emergency.

Why it's important to make POWER Account contributions

POWER Account contributions are a key part of the Healthy Indiana Plan. Members who make POWER Account contributions on time each month participate in HIP Plus where they have better benefits and predictable costs. Members with incomes above the poverty level, for example $11,670 a year for an individual, $15,730 for a couple or $23,850 for a family of four, that choose not to make their POWER Account contributions will be removed from the program and not be allowed to re-enroll for six months. This reenrollment lockout will not apply if the member is medically frail or residing in a domestic violence shelter or in a state-declared disaster area. If your income is below the poverty level and you fail to contribute to your POWER Account, you will be enrolled in HIP Basic where members are required to make copayments. Copayments are required each time members visit a doctor or hospital other than for preventive care or family planning services.

The HIP Basic health care plan will charge the following copayments for health care services.

Service	HIP Basic Co-Pay Amounts
Outpatient Services/Doctor Visits	$4 per service
Inpatient Services	$75 per stay
Preferred Drugs	$4 per prescription
Non-preferred Drugs	$8 per prescription
Non-emergency ER Visit	Up to $25 per visit

Unlike POWER Account contributions, which belong to the member and could be returned if the member leaves the program early, copays cannot be returned to the member.

HIP Basic members will be given the opportunity to reenroll in HIP Plus at the end of their benefit year.

Incentives for managing costs and getting preventive care

The Healthy Indiana Plan empowers members to make important decisions about the cost and quality of their health care. As an incentive, members who remain in the HIP Plus program can reduce their POWER Account contribution amounts after a year in the program based on the amount remaining in their accounts. For members who receive recommended preventive care services throughout the year, the discount will be doubled. Members in the HIP Basic plan also have a POWER Account and financial incentives for managing their accounts wisely and receiving preventive care.

How to apply?

Applications are available online, by mail or by visiting your local Division of Family Resources (DFR) office.

You can also call **1-877-GET-HIP-9 (1-877-438-4479)** and request an application be mailed to you.

Applications should be mailed to the following address:

FSSA Document Center
P.O. Box 1630
Marion, IN 46952

Prescription Assistance

Senior adults and individuals with disabilities are particularly affected by the high cost of prescription drugs. This booklet is intended to be a guide for these individuals and all Indiana residents who:

- Are receiving Medicare
- Need assistance finding and understanding ways to get prescription drug coverage.
- Need assistance in paying for their prescription drugs.

For assistance and additional information, call one of the SHIP counselors in your local area or call Indiana SHIP at 1-800-452-4800.

Some Tips to Help You Start Your Search:

- Talk to your doctor and/or pharmacist. Before choosing any source for filling your prescriptions, talk to your doctor and local pharmacist. They may be able to recommend a program that can help cover the costs of you prescription drugs.
- Keep a list of your medications. Keeping a list of your medications, including prescription drugs and over the counter drugs, saves you time and guesswork. It is also important to your doctor when prescribing medications. The medication list can be a critical factor should you need emergency care.
- Generic or Brand Name drugs? Not all brand name drugs have a generic drug substitute and are not always less expensive than brand name drugs. Ask your doctor or pharmacist if a generic medication can be substituted for a brand name, then compare prices.
- Consider a local pharmacy, a mail order or both. Some prescription drug services offer savings through local pharmacies. Another option is to use a mail order prescription drug service.
    - Local pharmacy programs are often beneficial for short-term, acute care prescriptions when convenience is desired
    - Mail order programs often provide greater savings for long-term maintenance drugs.

- Some companies and programs offer bot mail order and local pharmacy services.

Medicare Prescription Coverage (Part D)

On January 1, 2006, the new Medicare Prescription coverage started. This program is available to everyone with Medicare regardless of income, assets or health.

- Medicare Part D is Medicare prescription drug insurance that can help reduce your prescription drug costs. Through Medicare, private companies are offering plans.
- Joining is optional; however, you may have to pay a higher premium (+1% per month) if you choose to join after your initial enrollment period. If you already have prescription coverage that offers the same or better benefits than the standard Medicare Part D plans, you can keep that coverage and you won't have to pay a higher premium if you decide later to join. The annual enrollment period is from October 15 through December 7 of each year.
- To enroll in a Part D prescription plan contact the company that is offering the plan either by phone or by using their internet address.
- When you join a Part D plan, you will pay a monthly premium, an annual deductible (if this is a condition of the plan), and co-pays which are your share of each prescription cost.
- Medicare's "Model" Prescription Drug Coverage Plan for 2016 that companies offering Part D Plans have to equal or exceed includes:
    - Plans may require an annual deductible not to exceed $360.
    - After you have paid the deductible out of pocket, the Part D plan pays at least 75% of the drug costs until the total drug costs reach $3,310 for the year. Then begins the "gap" or period of no coverage.
    - The "gap" continues until your total out of pocket prescription costs reach $4,850 for the year, then your plan restarts coverage and pays at least 95% of covered prescription costs for the rest of the year.
- During the "gap", beneficiaries will pay 45% of the cost for brand name drugs and 58% of the cost for generic drugs.

- If your income and assets are under certain levels, the Social Security Administration offers the Extra Help assistance program that will pay all or part of your Part D Plan premiums, deductibles, eliminate the “gap” and reduce your co-pays.

Since January 1, 2006, Medigap policies providing drug coverage are not available for purchase. Medicare Supplemental insurance policies A through L will be available. You may continue current policies, but please note: the prescription coverage under Plans H, I or J are not considered to be creditable coverage by Medicare and there may be an increase in premiums if you decide to enroll later in Part D.

Those individuals having Plans H, I or J with prescription coverage may decide to join a Medicare Part D prescription plan. In this case, the prescription coverage through their Medigap plan will end and the company will adjust the premium.

Companies that sell Medigap policies may offer a separate discount program, unrelated to specific policies covering prescription drugs. Check with your insurance company for information on additional benefits that may be offered.

Do Medicare Advantages Plans Cover Prescription Drugs?

Some Medicare managed care plans cover prescription drugs. There may be an additional monthly premium increase for the prescription coverage.

Do Retiree Plans Cover Prescription Drugs?

Some do. If you have a retiree plan that supplements Medicare coverage, you may have some prescription drug coverage. For information about your plan’s drug coverage, contact your former employer’s HR representative or benefit specialist. If your retiree prescription drug coverage is equal to or better that Medicare’s coverage, you can keep your retiree drug coverage without penalty.

CAUTION: Before dropping the prescription part of a retirement or group health plan, check to see if this action will affect the other parts of the plan.

The Coverage Gap

Most Medicare Prescription Drug Plans have a coverage gap (also called the "donut hole"). This means there's a temporary limit on what the drug plan will cover for drugs.

Not everyone will enter the coverage gap. The coverage gap begins after you and your drug plan have spent a certain amount for covered drugs. In 2016, once you and your plan have spent $3,310 on covered drugs (the combined amount plus your deductible), you're in the coverage gap. This amount may change each year. Also, people with Medicare who get Extra Help paying Part D costs won't enter the coverage gap.

Once you reach the coverage gap in 2016, you'll pay 45% of the plan's cost for covered **brand-name prescription drugs**. You get these savings if you buy your prescriptions at a pharmacy or order them through the mail. The discount will come off of the price that your plan has set with the pharmacy for that specific drug.

Although you'll only pay 45% of the price for the brand-name drug in 2016, 95% of the price—what you pay plus the 50% manufacturer discount payment—will count as out-of-pocket costs which will help you get out of the coverage gap. What the drug plan pays toward the drug cost (5% of the price) and what the drug plan pays toward the dispensing fee (55% of the fee) aren't counted toward your out-of-pocket spending.

Example

Mrs. Anderson reaches the coverage gap in her Medicare drug plan. She goes to her pharmacy to fill a prescription for a covered brand-name drug. The price for the drug is $60, and there's a $2 dispensing fee that gets added to the cost. Mrs. Anderson will pay 45% of the plan's cost for the drug ($60 x .45 = $27) plus 45% of the cost of the dispensing fee ($2 x .45 = $0.90), or a total of $27.90, for her prescription. $57.90 will be counted as out-of-pocket spending and will help Mrs. Anderson get out of the coverage gap because both the amount that Mrs. Anderson pays ($27.90) plus the manufacturer discount payment ($30.00) count as out-of-pocket spending. The remaining $4.10, which is 5% of the drug cost and 55% of the dispensing fee paid by the drug plan, isn't counted toward Mrs. Anderson's out-of-pocket spending.

In 2016, Medicare will pay 42% of the price for **generic drugs** during the coverage gap. You'll pay the remaining 58% of the price. What you pay for generic drugs during the coverage gap will decrease each year until it reaches 25% in 2020. The coverage for generic drugs works differently from the discount for brand-name drugs. For generic drugs, only the amount you pay will count toward getting you out of the coverage gap.

Example

Mr. Evans reaches the coverage gap in his Medicare drug plan. He goes to his pharmacy to fill a prescription for a covered generic drug. The price for the drug is $20, and there's a $2 dispensing fee that gets added to the cost. Mr. Evans will pay 58% of the plan's cost for the drug and dispensing fee ($22 x .58 = $12.76). The $12.76 amount he pays will be counted as out-of-pocket spending to help him get out of the coverage gap.

If you have a Medicare drug plan that already includes coverage in the gap, you may get a discount after your plan's coverage has been applied to the price of the drug. The discount for brand-name drugs will apply to the remaining amount that you owe.

Items that count towards the coverage gap

Your yearly deductible, coinsurance, and copayments

The discount you get on brand-name drugs in the coverage gap

What you pay in the coverage gap

Items that don't count towards the coverage gap

The drug plan premium

Pharmacy dispensing fee

What you pay for drugs that aren't covered

Ways to Lower Costs in the Coverage Gap

Keep using your Medicare drug plan card

As the drug plan company will keep track of your out-of-pocket costs it is important that you continue to use your plan's card during the Coverage Gap. By using your plan's care you will be able to get your drugs at the plan's discounted rates

Consider switching to a generic, over-the-counter, or less expensive brand name drug

Check with your doctor to see if you can switch to a generic, over-the-counter, or less expensive brand name drug which will work as will with your other medications. Generic drugs are usually as effective as brand name drugs in treating medical conditions and are generally much less expensive.

Check with your pharmacy to see if they offer a discount program

You may be able to get a lower price for your drugs by using a discount card or pharmacy discount. You may use this discount and have it apply to your Part D plan's out-of-pocket costs. In order to do this you must use a pharmacy that is in the plan's network. Also, be sure to let your pharmacist know that you are in the Gap. You can submit your receipt to have the amount applied to your out-of-pocket expense. Check with your plan for specific details on how to submit your receipt.

Check out the National and Community Based Programs

Several pharmacies have drastically reduced the cost of generic drugs- for example Meijer, Wal-Mart, Kmart and Target. Many organizations offer programs to assist in paying for drug costs. Information on Federal, State and private programs available can be found from the following sources:

- Rx for Indiana – www.RxforIndiana.org or 1-877-793-0765
- Partnership for Prescription Assistance – www.pparx.org or 1-888-477-2669
- Benefit CheckUp – www.BenefitsCheckUp.org

- Needy Meds – www.needymeds.com

Look into Pharmaceutical Assistance Programs

Many pharmaceutical companies offer programs that provide free or low cost drugs to those in need regardless of age. Most of these programs have the following requirements:

- You do not have insurance that covers prescription drugs.
- You do not qualify for government assistance.
- Your income is within their stated guidelines.

Apply for Extra Help/LIS

If you meet the income and resource requirements, you may pay as little as $2.95 to $7.40 for each drug prescription. There is no Coverage Gap if you qualify for full Extra Help. You can apply through Social Security www.ssa.gov or by calling 1-800-772-1213.

Shop around for a Part D drug plan

Each year you will have the opportunity to change drug plans during the Annual Coordinated Election Period (October 15-December 7). Compare the coverage you have with other plans that are available to determine if you need to switch plans. You will be able to compare plans online at www.medicare.gov or by calling Medicare at 1-800-633-4227; TTY users 1-800-486-2048.

While there are ways to help lower your drug costs during the Coverage Gap, it is not always in your best interest to do so.

Once you have met the total out-of-pocket cost of $4,850 for 2016, you will enter Catastrophic Coverage. During Catastrophic Coverage your co-pays will be $2.95/$7.40. You will pay this amount through the end of the calendar year.

Medicare Prescription Drug Plans

Medicare offers prescription drug coverage to everyone with Medicare. If you decide not to join a Medicare Prescription Drug Plan (Part D) when you're first eligible, and you don't have other creditable prescription drug coverage, or you don't get Extra Help, you'll likely pay a late enrollment penalty.

To get Medicare drug coverage, you must join a plan run by an insurance company or other private company approved by Medicare. Each plan can vary in cost and drugs covered.

2 ways to get drug coverage

- Medicare Prescription Drug Plan (Part D). These plans (sometimes called "PDPs") add drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private Fee-for-Service (PFFS) Plans, and Medicare Medical Savings Account (MSA) Plans.
- Medicare Advantage Plan (Part C) (like an HMO or PPO) or other Medicare health plan that offers Medicare prescription drug coverage. You get all of your Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage, and prescription drug coverage (Part D), through these plans. Medicare Advantage Plans with prescription drug coverage are sometimes called “MA-PDs.” You must have Part A and Part B to join a Medicare Advantage Plan.

When considering a Medicare Prescription Plan, please keep in mind:

- Does the plan cover your medications?
- Is the prescription coverage from a Stand Alone plan; separate from a Medicare Advantage Plan, or is it an option with a Medicare Advantage Plan?
- Is the plan available in your county of residence?
- Is the pharmacy that accepts the plan convenient to you and/or does a pharmacy that accepts the plan have mail-order service?
- What is the monthly premium for the plan?
- Compare co-pays and/or coinsurance with other plans.
- Does the plan require an annual deductible?

Help with Part D Plan Costs
Extra Help/LIS

Ways You May Qualify for Extra Help

You may automatically qualify for Extra Help and do not need to apply.

- You have Medicare, full Medicaid coverage and live in a nursing home.
- You have Medicare and full Medicaid.
- You get help paying your Medicare premiums from the Medicare Savings Program (QMB, SLMB, QI).
- You have Medicare and receive Supplemental Security Income (SSI) but are not receiving Medicaid coverage.

Each month, Medicaid will send verification of the previously mentioned categories. All other people with Medicare must file an application to get Extra Help.

If your annual income is $17,505 or less ($23,595 if married and living with your spouse) and your resources are $13,440 or less ($26,860 if married and living with your spouse), you may qualify for Extra Help. You will need to apply. You can do this by calling the Social Security Administration (1-800-772-1213), visit www.ssa.gov on the web or apply at your local Medicaid office.

Extra Help (Low Income Subsidy)	**2015**
Co-payments	
Institutionalized	$0
Full Subsidy up to or at 100% Federal Poverty Level	$2.55/ $6.35
Full Subsidy above 100% Federal Poverty Level	$2.55/ $6.35
Partial Subsidy Deductible/Cost Share	$63/ 15%

Extra Help is not available to people in U.S. territories. The territories have their own rules for providing help with Medicare drug plan costs to their residents. See charge on following pages for detail on Extra Help.

2015 Medicare Prescription Drug Extra Help Benefit (Part D)

Full Subsidy Extra Help		
If you have…	**What do you get?**	**What should you do?**
Medicaid only	You are not eligible for Medicare Prescription Drug Benefits	Medicaid will continue to cover your prescriptions
Medicaid & Medicare OR: or Medicare Savings Program QMB, SLMB, or QI or Medicare & SSI	You are eligible for Extra Help You will pay: No premium * No deductible No gap in coverage	You do NOT need to apply for Extra Help. You are already eligible.
AND:		
Yearly Income above $11,670 (single) or $15,730 (married)	$1.20- $3.60 co-pay for prescriptions	
OR:	**OR:**	
Yearly Income below $17,505 (single) or $23,595 (married)	$2.55 - $6.35 co-pay for prescriptions ***No premium if the Standard Plan's premium is at or below the state benchmark.**	
If you have…	**What do you get?**	**What should you do?**
Medicare with no prescription coverage Yearly income below: $15,754.50 (single) or $21,235.50 (married) AND	You are eligible for Extra Help, but you must apply. No premium* No deductible No gap in coverage	Apply for Extra Help Select and enroll in a Drug Plan. You may want to also apply for the Medicare

Resources less than $8,660 (single) or $13,750 (married)	Co-pay of $2.55 or $6.35 *No premium if the Standard Plan's premium is at or below the state benchmark.	Savings Program. This program can help you with paying your monthly Part B premium.
Partial Subsidy Extra Help		
If you have…	**What do you get?**	**What should you do?**
Medicare with no prescription coverage Yearly income below $17,505 (single) or $23,595 (married) AND Resources less than $13,440 (single) or $26,860 (married)	You are eligible for Extra Help, but you must apply. $63 deductible 15% coinsurance No gap in coverage Sliding Scale Premium** (see chart on next page)	Apply for Extra Help Select and enroll in a Drug Plan.

Partial Subsidy Extra Help Sliding Scale Premium**			
If your income is:	**Single Income**	**Married Income**	**What you will pay in monthly premium**
135% Federal Poverty Level or lower	Below $15,754.50	Below $21,235.50	0% of the premium
135% - 140% Federal Poverty Level	$15,754.50 - $16,338	$21,235.50 - $22,022	25% of the premium
140% - 145% Federal Poverty Level	$16,338 - $16,921.50	$22,022 - $22,808.50	50% of the premium
145% - 150% Federal	$16,921.50 - $17,505	$22,808.50 - $23,595	75% of the premium

Poverty Level			

HoosierRx

HoosierRx Helps Pay for your Medicare Part D Plan

Indiana's State Pharmaceutical Assistance Program, HoosierRx, can help pay the monthly Part D premium, up to $70 per month, for members enrolled in a Medicare Part D Plan working with HoosierRx.

To be eligible for HoosierRx you must:

- Be an Indiana resident, 65 years old or older.
- Have a yearly income of $17,895 or less for a single person, or $24,135 or less for a married couple living together.
- Have applied for the "Medicare Extra Help" through Social Security to pay for your Medicare Part D plan, and received either a "Notice of Award" or "Notice of Denial" from Social Security.
    - Your Social Security "Notice of Denial" must be because your **resources are above the limit established by law.**
    - Your Social Security "Notice of Award" must state that you are receiving **partial extra help** subsidy to help pay for your Medicare Part D premium.

If you think you meet these eligibility requirements please call a HoosierRx representative at **1-866-267-4679.** Click the link for a printable version of the HoosierRx Flyer.

Companies offering Prescription Drug Plans working with HoosierRx:

AARP/United HealthCare, CIGNA, Indiana University Health Plans (with Part D coverage), Community CCRx, EnvisionRx, First Health, SilverScript, and WellCare.

Medicaid and Prescription Drugs

Does Medicaid Cover Prescription Drugs?

- If you have both Medicare and Medicaid ("Duel Eligible"), you will be assigned to a new Medicare prescription plan (Part D). If your new Medicare Prescription Plan is not right for your situation, you will have the option of changing plans.
- Your new plan will pay for your prescription cost unless your medication is not one of the classifications covered by Medicare.
- Medicaid may cover some over-the-counter medications.
- If your Part D plan does not cover a particular brand name, you (or doctor or pharmacist) can appeal to Medicare to have the brand covered. For example, drugs for mental illness require a stabilization period. To change drugs, may cause a setback so the doctor or pharmacist can appeal to have the current drug covered. The Part D plan has to provide an emergency supply during the 72 hour appeal process.
- It is not a requirement that you have Medicare to qualify for Medicaid, and you do not automatically qualify for Medicaid if you do have Medicare.
- If you are approved for Medicaid and do not have Medicare, Medicaid will continue helping with your prescription drug costs.
- In 2015, you may be eligible for Medicaid if you have income and assets below the following amounts:

	Income	Assets*
Single	$981 per month	$2,000
Couple	$1,328 per month	$3,000

*Assets normally do not include your home and one vehicle

Other Prescription Assistance

Pharmaceutical Manufacturers' Assistance

Many pharmaceutical companies offer programs that provide free or low cost drugs to those in need regardless of age. Most of these programs have the following requirements:

- You do not have insurance that covers prescription drugs.
- You do not qualify for government assistance.
- Your income is within their stated guidelines.

How Do I apply?

The application process is different for each company. Usually a doctor must sign your completed application form and have his/her office submit it for you. Most applications and instructions are available to you or your doctor's office through Rx for Indiana:

www.RxforIndiana.org or 1-877-793-0765

Other helpful resources:

www.needymeds.com or 1-800-503-6897

www.RxHope.com

Indiana Local Assistance

Township Trustees

- Eligibility: Please visit your local Township Trustee office for information regarding eligibility.
- Benefits: Emergency loan assistance for health care, prescription drugs, food, clothing, etc.
- Information: For eligibility requirements and information, visit your local Trustee office. Call 1-888-482-4639 for locations or www.indianatownshipassoc.org .

Indiana Area Agencies on Aging (AAA)

Indiana's Area Agencies on Aging provide case management, information and referrals to various services for individuals who are aged or are disabled. These services may include:

- Transportation
- Meals
- Employment
- Legal Services
- Adult Protection
- Attendant and/or Respite Care
- Affordable Housing
- Home Modification

To apply and for more information contact the Area Agency on Aging nearest you or call toll free 1-800-986-3505. A listing of local agencies can also be found at www.in.gov/fssa/elderly/aaa/index .

Community Health Centers

Community Health Centers provide medical services to people on a sliding fee scale. The centers may not have a pharmacy; however, they may have samples of prescription medications available for patients. Some centers may be able to help patients access prescription drugs at a discount.

The centers are also Federally qualified to waive Medicare Part B deductibles. The Indiana State Department of Health has been able to use the State Funded Community Health Center Program to build a strong network of primary and preventive health care providers throughout the state.

Military

Veterans' Benefits

Outpatient pharmacy services are provided free to veterans receiving medication for treatment of service-connected conditions. Other honorably discharged veterans may be charged $9 for each 30-day supply. In order to receive these benefits, you must fill out an application to enroll in the VA health care system. An application may be obtained by calling 1-877-222-8387. You must see a doctor at the VA before a prescription will be filled; a prescription from a no-VA doctor will not be accepted. For general information about VA pharmacy services, contact the Veteran s Administration at 1-800-827-1000.

Military Retiree Benefits

Any active duty or retired US military person, and/or their dependents are entitled to prescription drug coverage as part of their benefits. For more information, contact your local military installation or your specific military branch retirement division. Veterans in Indiana can call Toll Free 1-888-878-6889 ext 5404, or in the Indianapolis area 317-554-0000 ext 5404.

Tricare Senior Pharmacy Program

Uniformed services beneficiaries age 65 and over may obtain low cost prescription medications from the National Mail Order Pharmacy (NMOP) and Tricare network and non-network civilian pharmacies. Beneficiaries can continue to use military hospitals and clinic pharmacies. To qualify:

- You must be age 65 or older
- You must be registered in DEERS. Enrollment can be completed online at www.Tricare.osd.mil
- You must be enrolled in Medicare Part B if you are age 65 or older.

For specific information contact Tricare at 1-800-941-4501.

Discount Prescription Programs

Discount programs are not considered to be equal to Medicare's prescription drug program. If you are enrolled in a drug discount plan and decide to join a

Medicare prescription drug plan, your current plan benefits may change or be cancelled. Contact your current plan for details.

Online Ship Information

A special website is available to all SHIP Counselors. On this website you can search for SHIP counselors, search for SHIP in any state, and you may enter **Client Contact and PAM forms**. The website is **https://shipnpr.acl.gov**

To the left you will see the two boxes labeled: Username (your e-mail), and Password. These will be assigned to you by SHIP and are confidential. Then click on "GO".

Next click "Yes". Then read the statement and click on "I Agree". This will take you to the page where you can enter your Client Contact and PAM forms.

At the top of the page you find a series of choices. Pick the appropriate box. **(For example, click on "CC" (Client Contact)**. This will bring up the page where you enter your Client Contact form information. At the top right of the page is two underlined options: Do you want to add a new CC Form, or want to look at a CC Form that has been previously entered.

When you click adding a new CC Form, several of the boxes will already be completed due to your signing on to this site. To the left of many of the boxes will be a **RED STAR**. This indicates those boxes which are required to be completed. Please mark all of the boxes that you covered with your client.

When you enter the amount of time that you spent assisting your client, include:

- The time to make the appointment.
- Time spent gathering information for the appointment.
- Time spent in the counseling session.
- Add time if you are having information sent to the client.
- Be sure to include the time it takes to complete the CC Form.

At the bottom of this page, (you must scroll down), you will see a box that is marked, "**CMS Special Use Fields**", then to the left of the box is:

MIPPA CLIENT 1 2 3:

If you assisted your client with applying for **LIS enter 1**
If you assisted your client with applying for **MSP enter 2**
If you assisted your client with applying for both **LIS & MSP, enter 3**

If you took notes while talking with the client and want to save those notes, you may type them into the box at the bottom of the page. Remember, this is a secure website so you may enter any information that you may wish to recall later.

Should you forget to enter information into any Red Star boxes, when you are finished and click on "**SUBMIT**" the page will inform you as to what boxes were not completed. The information will be in red letters at the top, bottom, and under the empty box. Fill in the required information and click on "**SUBMIT**". If you correctly completed the form, at the top of the page will appear "**SUCCESS**".

At the bottom of the page as you sign you see all of the client contact forms that you have entered. Should you need to edit any of the information on a previously completed form you simply click on "**Edit**", make the changes, and then click on "**SUBMIT**".

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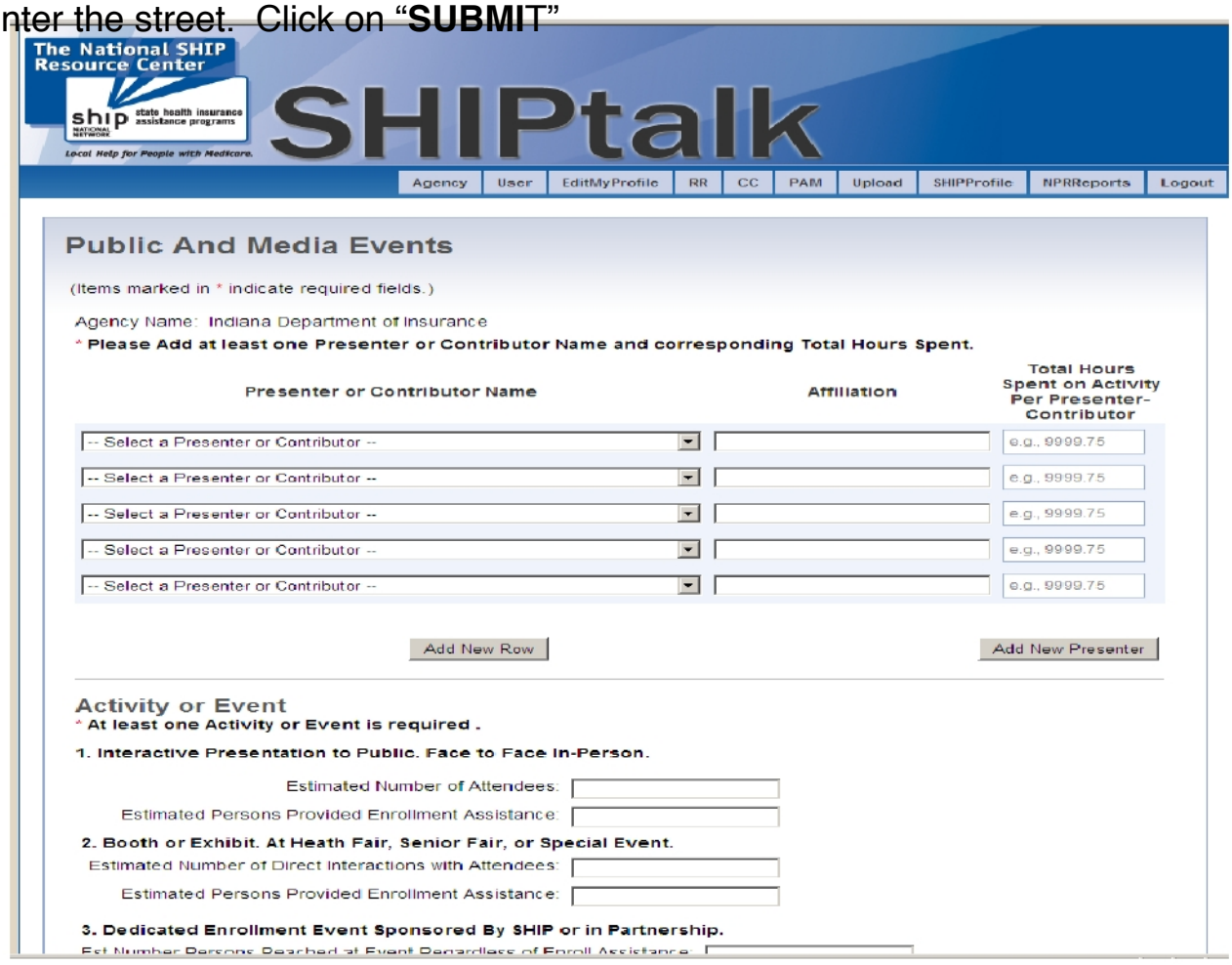
PAM FORMS
PUBLIC AND MEDIA

This form is used when you participate as a SHIP Counselor in a public activity. For example:

Booths at Health Fairs
Public Presentation
Dedicated Enrollment Events
Radio and/or TV or Cable, Live or Taped
Newspaper Columns or Ads
Pamphlets and/or Organization News Letters

At the top of the page is a section for Presenter. We recommend that each SHIP Counselor who was involved complete a PAM form.

Where it asks the number of persons of listeners reached, you may have an actual headcount, or, if it is Radio or TV, ask the event sponsor what is the estimated audience. Where it asks for the Street Address, if you don't know just enter the street. Click on "**SUBMIT**"



MyMedicare.gov

MyMedicare.gov is a secure, online service for accessing your own Medicare information. In order to access your information, you can either go to **www.medicare.gov**, and chose the **MyMedicare** box on the left, or go to:

www.MyMedicare.gov

This page allows you to register for **MyMedicare.gov**, and advises you about the information you will be able to access once you are registered and receive your password. This information includes the following:

- View claims status (excluding Part D claims)
- Order a duplicate Medicare Summary Notice or replacement Medicare card.
- View eligibility, entitlement, and preventive services information.
- View enrollment information including prescription drug plans.
- View and modify your drug list and pharmacy information.
- View address of record with Medicare and Part B deductible status.
- Access on live forms, publications, and messages sent to you by CMS.

Go half-way down the page to the line that reads, "**Register Information**". If you have not registered for MyMedicare.gov, please click here to begin the registration process. Click on the highlighted "click here".

Complete the registration form. All fields marked with a red * must be completed. The required information includes the following:

- Your Medicare Number
- Your last name
- Our date of birth
- Your gender
- Your zip code
- Choose a "Shared Secret Question" from the drop menu
- The answer to the chosen question
- Your relationship to the beneficiary

Once all fields are completed, use your mouse to click on the "**Continue**" button. After clicking the "Continue" button, the information you provided will be compared to the information in CMS's records.

Once the comparison has been made, you will receive a confirmation page. This page will include your username which is your Medicare claim number. To the right of the page you will find a copy of the welcome letter your will receive with your password.

For security purposes, **you will receive your password via mail in approximately 14 days**. This password is a one-time only password. You will not be able to access your Medicare information online until you receive your password.

The first time you log on with the password you receive through the mail from CMS, you will go to the line that reads, "**Already Registered**?" If you have already registered for MyMedicare.gov or have received your password in the mail and are logging on for the first time, "**click here to sign-in**". The will then be asked to change your password.

To login you need to type in your **Medicare number without dashes** as it appears on your red, white, and blue Medicare card. Be sure to **type in your one-time only password exactly** as it appears on your welcome letter.

After you enter your Medicare number and one-time password make sure you click on the "**login button only once**". You should see a pop-up window informing you that your request is being processed. You will have three changes to login successfully. After the attempt you will be temporally locked out for 30 minutes.

Once you have successfully logged in you will be asked to change your password. Your password must follow CMS guidelines:

- Be at least 6 characters but no more than 8.
- Be a mixture of letters and numbers, but must begin and end with a letter, and be different from the previous six passwords.
- Once you have registered, you will see the "Home Page". On the following page is listed what information you will see on the Home Page.

Home screen displays:

- A personalized greeting with your name, day, and date
- A message notification alerting you to the number of messages from CMS. A link is also provided which will take you to the “my messages” tab where you can view your inbox
- Your 5 most recent claims
- Your Part B deductible status
- Your Medicare eligibility
- A search box in order to search for Medicare related information on Medicare.gov
- A page layout table where you can change the font size or the order of the information shown on the home page.
- A Preventive Services notification alerting you to the number of preventive services which you are currently eligible to receive. A link to the “My Preventive Services” tab. Is also provided.
- Monthly health observance announcements with a link to Medicare.gov for health observance information. **NOTE:** not all months appear.

The Tabs on the Home Screen:

- The “Home” view displays information listed on the previous 1-9 items
- Select the “My Claims” tab to do a broader search for Part A, B, and DMERC (Durable Medical Equipment Regional Carriers claims which have been received, processed, and finalized by Medicare
- Select the “My Drugs” tab to view or modify your drugs and pharmacy information
- Select the “My Enrollment” tab to show your Medicare information
- Select the “My Preventive Services” tab to see your Medicare covered preventive services
- Select “My messages to see CMS sent messages
- Select the “My Profile” tab to view the address SSA has for you, your e-mail address, change your password, or request a replacement card.

- Select the “My Links” tab to obtain additional information on how to file a claim or an appeal.

Finding a Medicare Prescription Drug Plan

The Medicare website is an important tool in choosing a drug plan. The Medicare website is found at:

www.medicare.gov

To access the plan finder tool, go to the line that reads, “Compare Drug and Health Plans”. Click on this line.

To compare drug plans go to the line that reads, “Medicare Plan Finder”
You can do a General Search or a Personal Search. The difference is that if you enter all of your information on the Personal Search it will be saved and you will not have to reenter when going back onto this website. This will take you to the plan search page.
This page will also allow you to do the following:

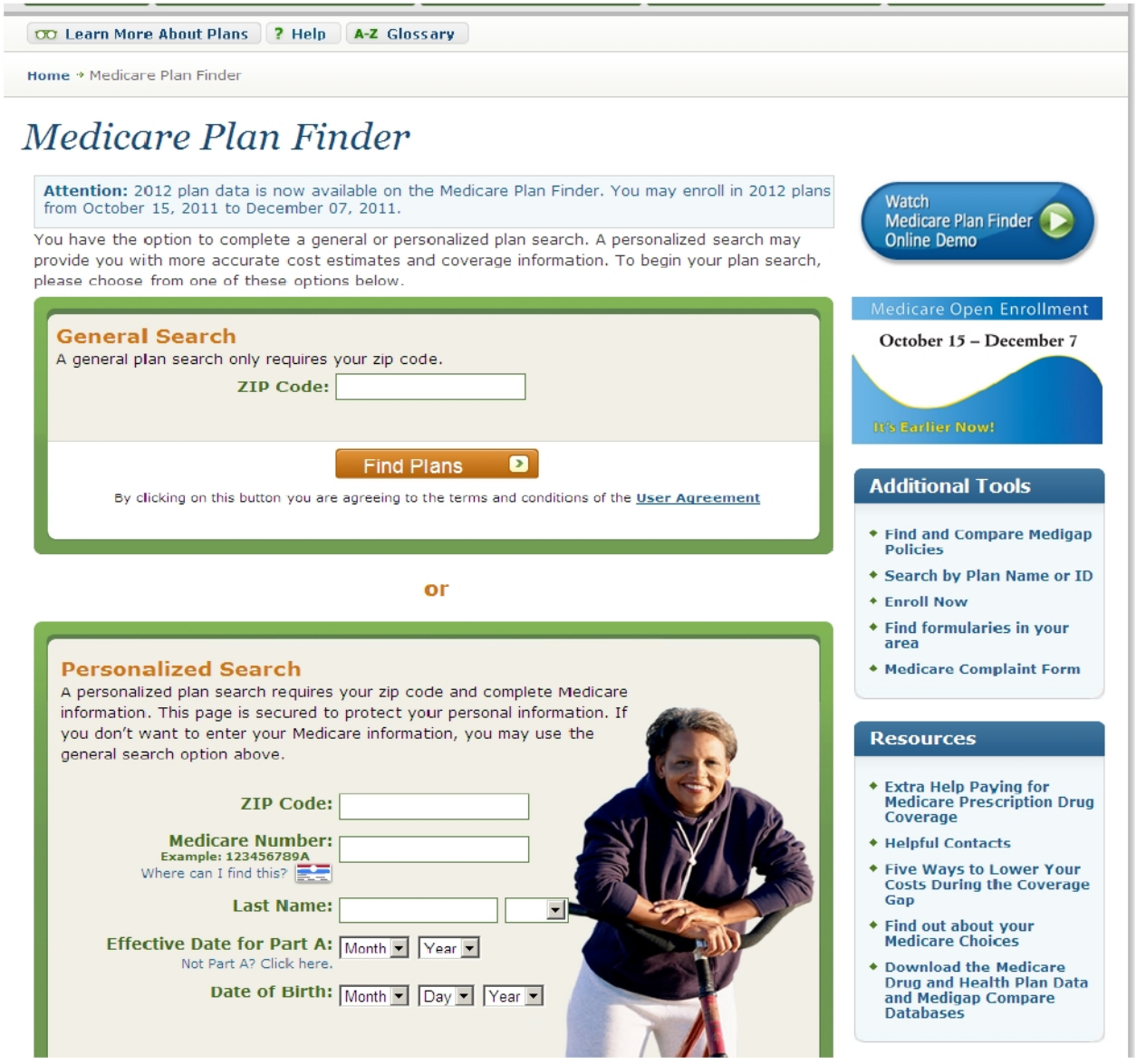
- View your current plan
- Enroll in a Medicare Prescription Drug Plan
- Learn how the Medicare Prescription Drugs Plans work
- View important coverage information for an individual who currently
- Receives prescription drug coverage through Military retiree benefits (TRICARE), Veteran benefits (VA), or Federal Employee retiree
- Benefits (FEHEP)

On this page you can choose to do a Personalized or General Search

In a personalized search type the following information

- Your Medicare claim number
- Your last name
- Your date of birth
- The effective date for your Medicare coverage
- Your zip code

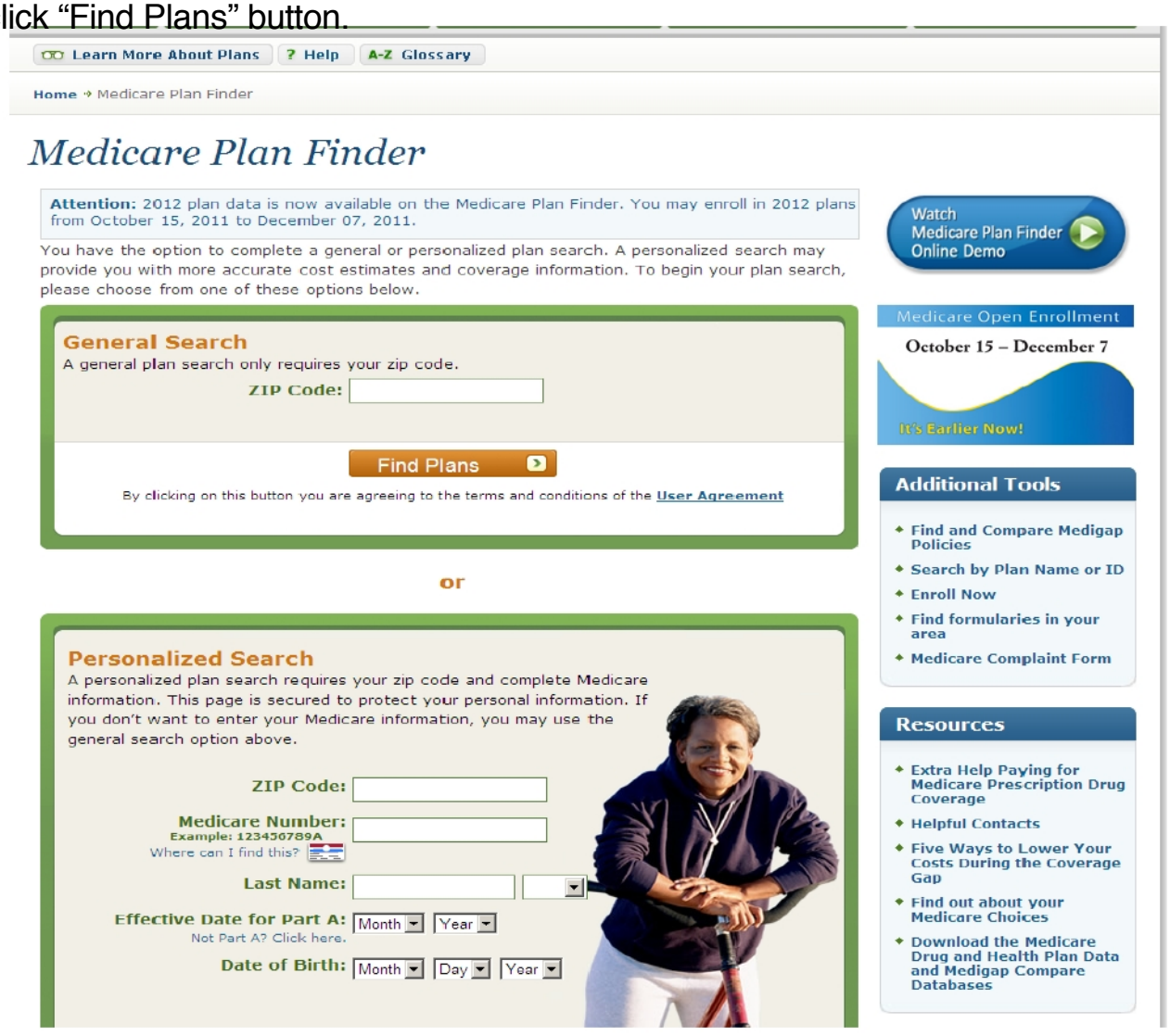
A general search will take you to the next page



On this page when doing a Personalized Search, you will need to input:

- Your zip code
- Your Medicare number (no hyphens and don't forget the letter
- Your current prescription drug coverage
- Your last name
- Your effective date for Part A
- Your date of birth
- Your current health coverage
- If you have received information about your eligibility for Extra Help (LIS-Low Income Subsidy through Social Security)

Click the "Continue" button. When doing a General Search, enter your zip code and click "Find Plans" button.



This screen will review the information you entered and give you general information about your options for plans. Once you have reviewed this information, click "continue"

First time users will need to go to the "**Enter My Drugs**" button and click.
Note for returning users", if you saved your drug list, you can input the confirmation number and password.

In order to determine the best drug plan for you, you will need to see if your current medications are included in the drug plan's formulary (list of approved drugs).

To find your medication by name, input the name of your medication. If you are not certain about the correct spelling of a medication use the alphabet by clicking on the first letter of the drug. Be sure to pick the correct dosage. You may type the full name, or just the first few letters of the drug. You will need to click the "**Search for Drug**".

- You will repeat the process until all of your drugs are listed

- Drug names in all capital letters are generic drugs.

- Drug names in grey are prohibited from being included in a part D formulary.

Once all of your drugs are listed you will select the "**Continue**" button.

This page allows you to enter the dosage and quantity amounts. This page defaults to the most common prescribed amounts. You can change the dosage by clicking the little arrows following the drug name.

You are also able to input additional drugs at this stage. Once all information has been updated you can continue by clicking "**Continue**".

At this point you may save the information you have put in by selecting a password date. This date can be any date, not just the current date. You will be sent to another page with a random code. This will allow you to return and complete the drug finder or review the information. This step is optional and is not required to continue.

An optional selection will allow you to select a particular pharmacy that you prefer. To select a pharmacy you will need to click on the small white box next to the address. You select two pharmacies. The pharmacies within 0.5 miles of your zip code will be listed. *To increase the search for pharmacies, you can scroll down toward the bottom of the page for options to increase the search radius*.

Note: **By selecting specific pharmacies you may not find the least expensive plan**. You will be limiting yourself to the prices negotiated between the drug plans and pharmacies you have selected.

The next page offers several options. You can compare plan details by clicking the white boxes to the left of the plan name and clicking "**Compare up to 3 Plans**". You can enroll in a plan by clicking the "**Enroll**" button.
You can sort plans by any of the following categories:

- Plan name
- Estimated Annual cost
- Annual Deductible
- Monthly Drug Premium
- Monthly Cost Share (the amount of co-pay or co-insurance)

To sort, click on the column title.

This page gives you a side by side comparison of up to three plans. You will be able to compare the plans in each of the phases of drug plan coverage:

- Phase1 – the deductible if applicable
- Phase 2 – partial coverage – cost before hitting the benefit gap
- Phase 3 – benefit gap

- Phase 4 – Catastrophic coverage

View Important Notes" and "**View Drug Details**" give important information that should be considered in choosing a plan.

"**View Drug Details**" will provide the following medication details;

- Price tier – where the drugs falls price wise in the formulary
- Drug cost – the current price with the drug plan
- Prior authorization – yes, while the drug is on the formulary, the plan must get prior approval to cover the drug
- Quantity limits – if yes, this places certain limits on the amount of the drug for a 30 day supply. This is for safety reasons
- Step therapy – the requirement of the use of lower cost drugs before the plan will cover a more expensive drug.

"**View Important Notes**" will give you details such as:

- Is the plan a regional, does it offer national coverage
- Does the plan have a network of pharmacies
- Is there an additional cost for going to out of network pharmacies
- The "**Estimated Annual Cost**" column is the one that gives you the most accurate evaluation to compare what the costs will be.

Each plan has a "**Star Rating" from1 to 5**. This gives a comparison as to how well the plan has been following the rules, providing beneficiaries assistance and information, and quality of service.

You may also follow these procedures when comparing Medicare Advantage Plans.

There are many services provided on this page to assist you in helping your clients. You can demonstrate to your clients how to go to this website and conduct their own information searches

The following pages give information on searching Advantage Plans.

FINDING

MEDICARE ADVANTAGE PLANS

TO COMPARE Medicare Advantage Plans: MA and/or MAPD

www.medicare.gov

Click on "**Compare Drug and Health Plans**". Again you will see the screen for "General Search" or "Personalized Search". Depending upon which you choose, you will be asked for a Zip code or personal information. Then you will be asked to enter your drugs. If you are only searching for MA (Medicare Advantage Plans) you can click on "**I don't want to enter drugs**". Then the results will show Advantage Plans for your area.

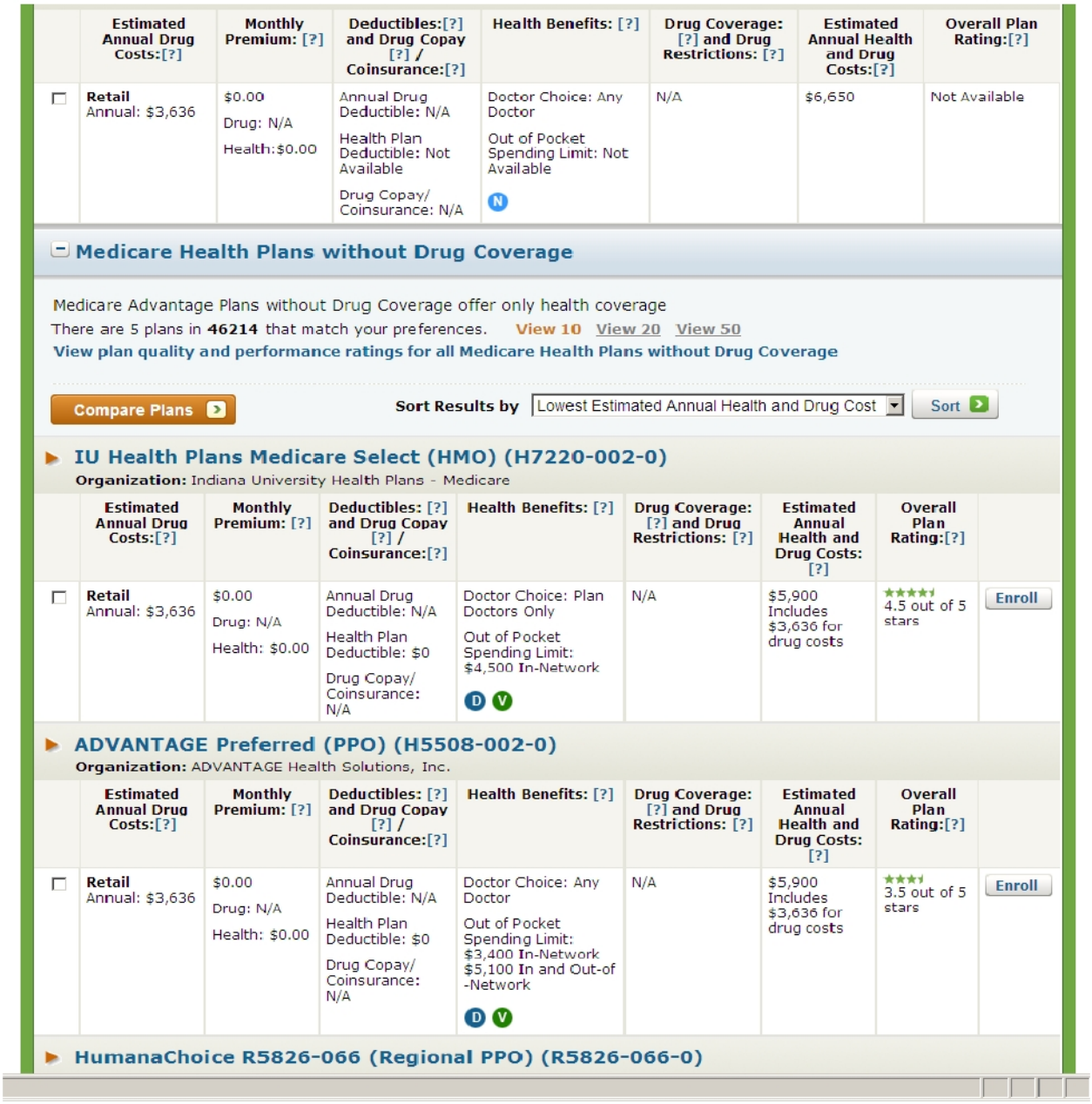
On the right you click in the box that is what you want to find:

- Prescription Drug plans with Original Medicare
- Medicare health Plans with drug coverage
- Medicare health Plans without drug coverage

The plans for your area will appear. At the top is Original Medicare so you can compare. (continued next page)

You may compare plans by clicking on the small box on the left of the plan, Then scroll down to the bottom right and click on "**Compare Plans**".

(continued next page)



	Estimated Annual Drug Costs:[?]	Monthly Premium: [?]	Deductibles:[?] and Drug Copay [?] / Coinsurance:[?]	Health Benefits: [?]	Drug Coverage: [?] and Drug Restrictions: [?]	Estimated Annual Health and Drug Costs:[?]	Overall Plan Rating:[?]
☐	**Retail** Annual: $3,636	$0.00 Drug: N/A Health:$0.00	Annual Drug Deductible: N/A Health Plan Deductible: Not Available Drug Copay/ Coinsurance: N/A	Doctor Choice: Any Doctor Out of Pocket Spending Limit: Not Available N	N/A	$6,650	Not Available

Medicare Health Plans without Drug Coverage

Medicare Advantage Plans without Drug Coverage offer only health coverage
There are 5 plans in **46214** that match your preferences. View 10 View 20 View 50
View plan quality and performance ratings for all Medicare Health Plans without Drug Coverage

Compare Plans | Sort Results by: Lowest Estimated Annual Health and Drug Cost | Sort

IU Health Plans Medicare Select (HMO) (H7220-002-0)
Organization: Indiana University Health Plans - Medicare

	Estimated Annual Drug Costs:[?]	Monthly Premium: [?]	Deductibles: [?] and Drug Copay [?] / Coinsurance:[?]	Health Benefits: [?]	Drug Coverage: [?] and Drug Restrictions: [?]	Estimated Annual Health and Drug Costs: [?]	Overall Plan Rating:[?]	
☐	**Retail** Annual: $3,636	$0.00 Drug: N/A Health: $0.00	Annual Drug Deductible: N/A Health Plan Deductible: $0 Drug Copay/ Coinsurance: N/A	Doctor Choice: Plan Doctors Only Out of Pocket Spending Limit: $4,500 In-Network D V	N/A	$5,900 Includes $3,636 for drug costs	4.5 out of 5 stars	Enroll

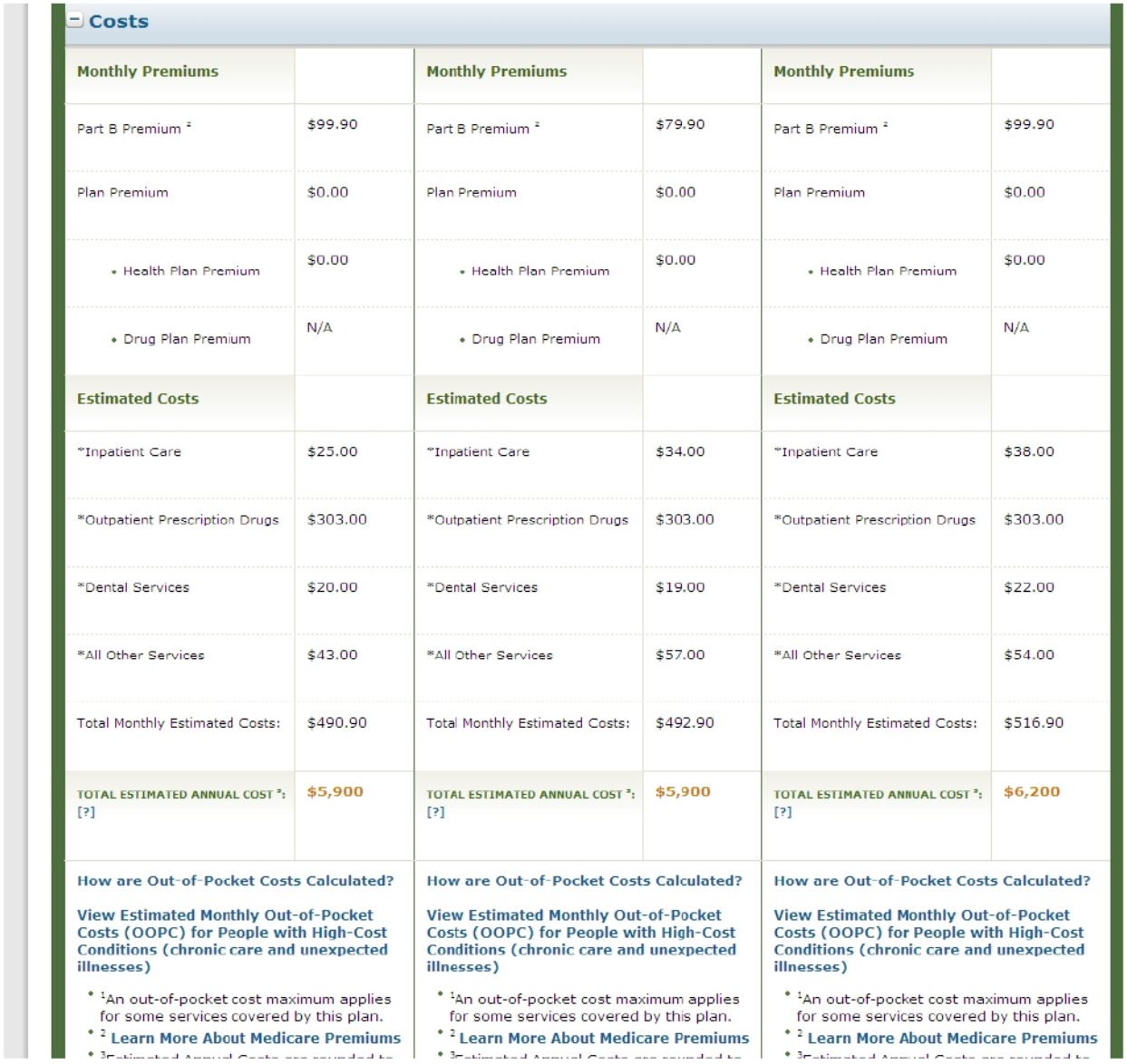
ADVANTAGE Preferred (PPO) (H5508-002-0)
Organization: ADVANTAGE Health Solutions, Inc.

	Estimated Annual Drug Costs:[?]	Monthly Premium: [?]	Deductibles: [?] and Drug Copay [?] / Coinsurance:[?]	Health Benefits: [?]	Drug Coverage: [?] and Drug Restrictions: [?]	Estimated Annual Health and Drug Costs: [?]	Overall Plan Rating:[?]	
☐	**Retail** Annual: $3,636	$0.00 Drug: N/A Health: $0.00	Annual Drug Deductible: N/A Health Plan Deductible: $0 Drug Copay/ Coinsurance: N/A	Doctor Choice: Any Doctor Out of Pocket Spending Limit: $3,400 In-Network $5,100 In and Out-of -Network D V	N/A	$5,900 Includes $3,636 for drug costs	3.5 out of 5 stars	Enroll

HumanaChoice R5826-066 (Regional PPO) (R5826-066-0)

By scrolling down on this page you can compare costs, deductibles, and at the bottom of the page it gives the annual estimated costs for each plan.

And if you are eligible and decide to enroll in one of these plans, scroll back to the top of the page and click on “Enroll”



Costs

Monthly Premiums		Monthly Premiums		Monthly Premiums	
Part B Premium [2]	$99.90	Part B Premium [2]	$79.90	Part B Premium [2]	$99.90
Plan Premium	$0.00	Plan Premium	$0.00	Plan Premium	$0.00
• Health Plan Premium	$0.00	• Health Plan Premium	$0.00	• Health Plan Premium	$0.00
• Drug Plan Premium	N/A	• Drug Plan Premium	N/A	• Drug Plan Premium	N/A
Estimated Costs		**Estimated Costs**		**Estimated Costs**	
*Inpatient Care	$25.00	*Inpatient Care	$34.00	*Inpatient Care	$38.00
*Outpatient Prescription Drugs	$303.00	*Outpatient Prescription Drugs	$303.00	*Outpatient Prescription Drugs	$303.00
*Dental Services	$20.00	*Dental Services	$19.00	*Dental Services	$22.00
*All Other Services	$43.00	*All Other Services	$57.00	*All Other Services	$54.00
Total Monthly Estimated Costs:	$490.90	Total Monthly Estimated Costs:	$492.90	Total Monthly Estimated Costs:	$516.90
TOTAL ESTIMATED ANNUAL COST [3]: [?]	$5,900	TOTAL ESTIMATED ANNUAL COST [3]: [?]	$5,900	TOTAL ESTIMATED ANNUAL COST [3]: [?]	$6,200

How are Out-of-Pocket Costs Calculated?

View Estimated Monthly Out-of-Pocket Costs (OOPC) for People with High-Cost Conditions (chronic care and unexpected illnesses)

- [1] An out-of-pocket cost maximum applies for some services covered by this plan.
- [2] **Learn More About Medicare Premiums**

CLIENT AGREEMENT FORM

I understand that:

- The State Health Insurance Assistance Program (SHIP) is a state-sponsored, *non-profit* program for Medicare beneficiaries, persons about to be eligible for Medicare, and persons interested in long term care insurance information.
- Counseling services are intended to *help me understand* Medicare, Medicare supplement insurance, long term care insurance, and other health insurance options in an objective manner that supports my independent decisions.
- Counseling services are provided by trained volunteer counselors acting in good faith, to provide information about health insurance policies to me, the client. This information shall not be construed to be legal advice.
- Trained volunteer counselors are neither affiliated with the insurance industry nor financial planners. Counselors do not sell, recommend, or endorse any specific insurance product, agent, insurance company, or provider of service.
- Counseling is confidential and free of charge.
- The volunteer *counselor assumes no responsibility* for decisions for actions taken by me, as a result of counseling.

I, therefore, hold harmless the State Health Insurance Assistance Program, the Indiana Department of Insurance, the Indiana Family and Social Services Administration, the State of Indiana, the Sponsoring Organization, and the volunteer counselor, for any losses, claims, costs, damages, or liability arising out of or in connection with any act or omission on the volunteer counselor, the Sponsoring Organization, the State of Indiana, the Indiana Family and Social Services Administration, the Indiana Department of Insurance, and SHIP, in connection with this Agreement.

Client's Signature _____ Date _____

Counselor's Signature _____

Date _____

POLICY RETURN LETTER

Date: _____

Insurance Company: _____

Address: _____

_____

Re: Your Policy Number: _____

The enclosed policy was received by me on _____.
After examining the policy, I am not satisfied with it and request a full refund in the amount of $_____that I paid on,
Date: _____.

Respectfully Yours,

_____
Client's signature

Client's Name: _____

Address: _____

_____

Note to Client: Be sure to enclose your policy, a copy of your receipt or cancelled check, and keep a copy of this letter for your records.

INDIANA DEPARTMENT OF INSURANCE
CONSUMER SERVICES DIVISION
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204-2787
INSURANCE COMPLAINT FORM
(317-232-2395) or (800) 622-4461

In response to your request for assistance, please fill out this complaint form and return it to the above address.

COMPLETE BOTH SIDES OF THIS FORM.
TYPE OR PRINT CLEARLY IN BLACK INK.

Your Name: _____
Your Address: _____
_____
City State Zip Code
Daytime Telephone Number (_____)

1. (A) Type of Insurance (Please check One):

☐ Automobile	☐ Homeowners	☐ Fire	☐ Life
☐ Health	☐ Medicare Supplement	☐ Business	☐ Other

1. (B) If your complaint is about a Medicare Supplement policy, please give the type of policy : (A through L) _____
2. My complaint is against:
   Name of Insurance company_____
3. If an agent is involved, please give the agent's name and address.
   Name: _____
   Address: _____
4. Policy Number:_____

a. Claim Number (If known)_____

5. Name Insured:_____
6. If group insurance, please give name of employer:
   Name: _____
7. If loss or an accident is involved, please give the location and/or date of the loss.
   Date:____/____/____

Location:_____ _____ _____

City State Zip Code

8. Briefly describe your problem. If more space is needed, please attach additional sheets.

I hereby authorize the release of confidential medical and/or other information to the Department of Insurance. I understand that medical records WILL NOT be public record at any time.

SHIP'S Claims Record Form

		Medicare							Medicare Supplement		Balance of Bill		
	Date of Service	Assign-ment? Y or N	Actual Charge	Medicare Approved Amount	Limit-ing Charge	Applied to Medicare Deductible	Amount paid by Medicare	Amount of bill leftover	Date bill sent to Med-Sup	Amount paid by Med-Sup	Amount paid upfront to Provider	Balance due to Provider	Date balance paid to Provider

Provider of Service (etc)

Frequently Used Acronyms

A

AAA – Area Agency on Aging
ADA – Americans with Disabilities Act of 1990
ADL – Activities of Daily Living
ADRC – Aging & Disability Resource Center
AEP – Annual Coordinated Election Period
ALJ – Administrative Law Judge
ALS – Amyotrophic Lateral Sclerosis

B

BBA – Balanced Budget Act of 1997
BHA – Bureau of Hearing and Appeals

C

CDC – Centers for Disease Control
CHOICE - Community and Home Options to Institutional Care for the Elderly and Disabled
COB – Coordination of Benefits
CMS – Centers for Medicare and Medicaid Services
COBRA – Consolidated Omnibus Budget Reconciliation Act of 1985
CTM – Complaints Tracking Module

D

DC - Diagnostic Code
DFR – Department of Family Resources
DME – Durable Medical Equipment
DMEMAC – Durable Medical Equipment Medicare Administrative Contractor
DMEPOS – Durable Medical Equipment Prosthetic, Orthotics & Supplies
DOD – Depart of Defense
DOE – Date of Entitlement
DOI – Department of Insurance
DOL – Department of Labor
DRG – Diagnosis Related Group
DVA – Department of Veterans Affairs
DWA – Disabled Working Aged
DWB – Disabled Widow's Benefits
DWI – Disabled Working Individual

E

EGHP – Employer Group Health Plan
HER – Electronic Health Records
EOB – Explanation of Benefits
EOC – Evidence of Coverage
ERx – Electronic Prescription Prescribing
ESRD – End Stage Renal Disease

F

F&A - Fraud & Abuse
FAQ – Frequently Asked Questions
FDS – Food & Drug Administration
FEHBP – Federal Employees Health Benefit Program
FFS – Fee-for-Service
FPL – Federal Poverty Level
FQHC – Federally Qualified Health Center

G

GEP – General Enrollment Period
GHP – Group Health Plan

H

HHA – Home Health Agency
HHABN – Home Health Advanced Beneficiary Notice
HHS – (Dept.) Health & Human Services
HIB – Hospital Insurance Benefits Part A
HIC – Health Insurance Claim
HICN – Health Insurance claim Number (Medicare Number)
HIPPA – Health Insurance Portability and Accountability Act of 1996
HMO – Health Maintenance Organization

HRSA – Health Resources & Services Administration

I

ICF - Intermediate Care Facility
ICHIA- Indiana Comprehensive Health Insurance Association
IDOI - Indiana Department of Insurance
IEP - Initial Enrollment Period
ILTCIP- Indiana Long term Care Insurance Partnership
IRC - Inpatient Respite Care
IRE – Independent Review Entity
IWD – Individuals With Disabilities

L

LGHP – Large Group Health Plan
LIS – Low Income Subsidy
KIS – Length of Stay
LRD – Lifetime Reserve Days
LTC – Long Term Care
LTF – Long Term Care Facility

M

MA - Medicare Advantage
MAC – Medicare Appeals Council
MAC – Medicare Administrative Contractor
MAPD – Medicare Advantage Plan with Prescription Drug Coverage
MCO – Managed Care Organization
MDFDF – Medicare Prescription Drug Plan Finder
MFS – Medicare Fee Schedule
MIPPA – Medicare Improvements for Patient and providers Act of 2008
MMA – Medicare Modernization Act of 2003
MSA – Medicare Savings Account
MSN – Medicare Summary Notice
MSP – Medicare Savings Programs
MSP – Medicare Secondary Payer

N

NAIC – National Association of Insurance Commissioners
NH – Nursing Home
NA – National Institute on Aging
NIH – National Institute of Health

NMEP – National Medicare Education Program
NMPT – National Medicare Training Program

O

OBRA – Omnibus budget Reconciliation Act of 1981/1987/1989/1990
OP – Outpatient
OPM – Office of Personnel Management
OPPS - Out Patient Prospective Payment System

P

PACE – Program of All-Inclusive Care for the elderly
PAS – Preadmission Screening
PBP – Plan Benefit Package
PDP – Prescription Drug Plan
PFFS – Private-Fee-for-Service (Plan)
PHR – Personal health Record
PO – PACE Organization
POS – Point of Service
PPO – Preferred Provider Organization
PSA – Prostate Specific Antigen
PSO – Provider Sponsored Organization

Q

QDWI – Qualified Disabled and working Individuals
QI – Qualified Individual
QIO – Quality Improvement Organization
QMB – Qualified Medicare beneficiary
QWDI – Qualified Working Disabled Individual (aka QDWI)

R

RDF – Renal Dialysis Facility
RFP – Religious Fraternal Organization
RH – Rural Hospital

RHC – Rural Health Center
RRB – Railroad Retirement board
RWF – Robert Woods Foundation (ILTCIP)

S
SSA – State Administering Agency
SEP – Special Enrollment Period
SHIP – State health Insurance Assistance Program
SLMB – Specified Low-Income Medicare Beneficiary
SMP – Senior Medicare patrol
SNF – Skilled Nursing Facility
SNP – Special Needs Plan
SOP – Standard Operating Procedures
SPAP – State Pharmacy Assistance Programs
SS – Social Security
SSA – Social Security Administration
SSDI – Social Security Disability insurance
SSI – Supplemental Security Income
SSN – Social Security Number

T
TFL – TRICARE For Life
TROOP – True Out-of Pocket
TTY – Teletypewriter

V
VA – Department of Veterans Affairs
VDS – Voluntary Data sharing

W
WA – Working Aged
WBT – Web Based Training

X
XMT – Transmit
XMTL – Transmittal
XVI –Title 16 Grants to States for Aid to the Aged, Blind, or Disabled or Aid & Medical Assistance for the Medicare Beneficiary
XVII – Title 18 Medicare Beneficiary
XXI – Title 21 State Child Health Program

Y
YOB – Year of Birth
YR – year
YTD- Year to Date
YYYY – Year (i.e.mmddyyyy)

Glossary

A "TIER"
Is a specific list of drugs. Your plan may have several tiers, and your co-payment amount depends on which tier your drug is listed. Plans can choose their own tiers, so members should refer to their benefit booklet or contact the plan for more information.

ABUSE
A range of the following improper behaviors or billing practices including, but not limited to:

- Billing for a non-covered service
- Misusing codes on the claim (i.e. the way the service is coded on the claim does not comply with national or local coding guidelines or is not billed as rendered)
- Inappropriately allocating costs on a cost report

ACCESS
Your Ability to get needed medical care and services.

ACCESSIBILITY OF SERVICES
Your ability to get medical care and services when you need them.

ACCESSORY DWELLING UNIT (ADU)
A separate housing arrangement within a single-family home. The ADU is a complete living unit and includes a private kitchen and bath.

ACCREDITATION
An evaluative process in which a healthcare organization undergoes an examination of its policies, procedures and performance by an external organization ("accrediting

body") to ensure that it is meeting predetermined criteria. It usually involves both on- and off-site surveys.

ACT/LAW/STATUE

Term for legislation that passed through Congress and was signed by the President or passed over his veto.

ACTIVITIES OF DAILY LIVING (ADL)

Activities you usually do during a normal day such as getting in and out of bed, dressing, bathing, eating, and using the bathroom.

ACTUAL CHARGE

The amount of money a doctor or supplier charges for a certain medical service or supply. This amount is often more than the amount Medicare approves. (See Approved Amount; Assignment.)

ADDITIONAL BENEFITS

Health care services not covered by Medicare and reductions in premiums or cost sharing for Medicare covered services. Additional benefits are specified by the MA Organization and are offered to Medicare beneficiaries at no additional premium. Those benefits must be at least equal in value to the adjusted excess amount calculated in the ACR. An excess amount is created when the average payment rate exceeds the adjusted community rate (as reduced by the actuarial value of coinsurance, co-payments, and deductibles under parts A and B of Medicare). The excess amount is then adjusted for any contributions to a stabilization fund. The remainder is the adjusted excess, which will be used to pay for services not covered by Medicare and/or will be used to reduce charges otherwise allowed for Medicare-covered services. Additional benefits can be subject to cost sharing by plan enrollees. Additional benefits can also be different for each MA plan offered to Medicare beneficiaries.

ADMINISTRATIVE LAW JUDGE (ADJ)

A hearings officer who presides over appeal conflicts between providers of services, or beneficiaries, and Medicare contractors.

ADMISSION DATE
The date the patient was admitted for inpatient care, outpatient service, or start of care. For an admission notice for hospice care, enter the effective date of election of hospice benefits.

ADMITTING DIAGNOSIS CODE
Code indicating patient's diagnosis at admission.

ADMITTING PHYSICIAN
The doctor responsible for admitting a patient to a hospital or other inpatient health facility.

ADULT LIVING CARE FACILITY
To be used when billing services rendered at a residential care facility that houses beneficiaries who cannot live alone but who do not need around-the-clock skilled medical services. The facility services do not include a medical component (Program memo B-98-28).

ADVANCE BENEFICIARY NOTICE (ABN)
A notice that a doctor or supplier should give a Medicare beneficiary when furnishing an item or service for which Medicare is expected to deny payment. If you do not get an ABN before you get the service from your doctor or supplier, and Medicare does not pay for it, then you probably do not have to pay for it. If the doctor or supplier does give you an ABN that you sign before you get the service, and Medicare does not pay for it, then you will have to pay your doctor or supplier for it. ABN's only apply if you are in the Original Medicare Plan. They do not apply if you are in a Medicare Managed Care Plan or Private Fee-For-Service Plan.

ADVANCE COVERAGE DECISION
A decision that your Private Fee-for-Service Plan makes on whether or not it will pay for a certain service.

ADVANCE DIRECTIVE (HEALTH CARE)
Written ahead of time, a health care advance directive is a written document that says how you want medical decisions to be made if you lose the ability to make decisions for yourself. A health care advance directive may include a Living Will and a Durable Power of Attorney for health care.

ADVOCATE
A person who gives you support or protects your rights.

AFFILIATED PROVIDER
A health care provider or facility that is paid by a health plan to give service to plan members.

AMBULANCE (AIR OR WATER)
An air or water vehicle specifically designed, equipped, and staffed for life saving and transporting the sick or injured.

AMBULANCE (LAND)
A land vehicle specifically designed, equipped, and staffed for life saving and transporting the sick or injured.

AMBULATORY CARE
All types of health services that do not require an overnight hospital stay.

AMBULATORY SURGICAL CENTER
A place other than a hospital that does outpatient surgery. At an ambulatory (in and out) surgery center, you may stay for only a few hours or for one night.

ANCILLARY SERVICES
Professional services by a hospital or other inpatient health program. These may include x-ray, drug, laboratory, or other services.

ANESTHESIA

Drugs that person is given before surgery so he or she will not feel pain. Anesthesia should always be given by a doctor or a specially trained nurse.

APPEAL

An appeal is a special kind of complaint you make if you disagree with a decision to deny a request for health care services or payment for services you already received. You may also make a complaint if you disagree with a decision to stop services that you are receiving. For example, you may ask for an appeal if Medicare doesn't pay for an item or service you think you should be able to get. There is a specific process that your Medicare Advantage Plan or the Original Medicare Plan must use when you ask for an appeal.

APPEAL PROCESS

The process you use if you disagree with any decision about your health care services. If Medicare does not pay for an item or service you have been given, or if you are not given an item or service you think you should get, you can have the initial Medicare decision reviewed again. If you are in the Original Medicare Plan, your appeal rights are on the back of the Explanation of Medicare Benefits (EOMB) or Medicare Summary Notice (MSN) that is mailed to you from a company that handles bills for Medicare. If you are in a Medicare managed care plan, you can file an appeal if your plan will not pay for, or does not allow or stops a service that you think should be covered or provided. The Medicare managed care plan must tell you in writing how to appeal. See your plan's membership materials or contact your plan for details about your Medicare appeal rights. (See also Organization Determination.)

APPROVED AMOUNT

The fee Medicare sets as reasonable for a covered medical service. This is the amount a doctor or supplier is paid by you and Medicare for a service or supply. It may be less than the actual amount charged by a doctor of supplier. The approved amount is sometimes called the "Approved Charge".

AREA AGENCY ON AGING (AAA)

State and local programs that help older people plan and care for their life-long needs. These needs include adult day care, skilled nursing care/therapy, transportation, personal care, respite care, and meals.

ASSESSMENT
The gathering of information to rate or evaluate your health and needs, such as in a nursing home.

ASSETS
Treasury notes and bonds guaranteed by the federal government, and cash held by the trust funds for investment purposes.

ASSIGNED CLAIM
A claim submitted for a service or supply by a provider who accepts Medicare assignment.

ASSIGNMENT
In the Original Medicare Plan, this means a doctor agrees to accept the Medicare-approved amount as full payment. If you are in the Original Medicare Plan, it can save you money if your doctor accepts assignment. You still pay your share of the cost of the doctor's visit.

ASSISTED LIVING
A type of living arrangement in which personal care services such as meals, housekeeping, transportation, and assistance with activities of daily living are available as needed to people who still live on their own in a residential facility. In most cases, the "assisted living" residents pay a regular monthly rent. Then they typically pay additional fees for the services they get.

ATTENDING PHYSICIAN
Number of the licensed physician who would normally be expected to certify and recertify the medical necessity of the number of services rendered and/or who has primary responsibility for the patient's medical care and treatment.

AUTHORITATIVE APPROVAL
Method or type of approval that requires a determination that the service is likely to have a diagnostic or therapeutic benefit for patients for whom it is intended.

AUTHORITATIVE EVIDENCE

Written medical or scientific conclusions demonstrating the medial effectiveness of a service produced by the following:

- Controlled clinical trials, published in peer-reviewed medical or scientific journals;
- Controlled clinical trials completed and accepted for publication in peer-reviewed medical or scientific journals;
- Assessments initiated by CMS'
- Evaluations or studies initiated by Medicare contractors;
- Care studies published in peer-reviewed medical or scientific journals that present treatment protocols.

AUTHORIZATION

MA approval necessary prior to the receipt of care. (Generally, this is different from a referral in that, an authorization can be a verbal or written approval from the MA whereas a referral is generally a written document that must be received by a doctor before giving care to the beneficiary).

AUTOMATED CLAIM REVIEW

Claim review and determination made using system logic (edits). Automated claim reviews never require the intervention of a human to make a claim determination.

BALANCE BILLING

A situation in which Private Fee-for-Service-Plan providers (doctors or hospitals) can charge and bill you 15% more than the plan's payment amount for services.

BASIC BENEFITS

Basic Benefits includes both Medicare-covered benefits (except hospice services) and additional benefits.

BASIC BENEFITS (MEDIGAP POLICY)

Benefits provided in Medigap Plan A. They are also included in all other standardized Medigap policies. (See Medigap Policy.)

BENEFICIARY
The name for a person who has health care insurance through the Medicare or Medicaid program.

BENEFIT PERIOD
The way that Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you haven't received any hospital care (or skilled care in a SNF) for 60 days in a row. If you go into the hospital or skilled nursing facility after one benefit period has ended, a new benefit period begins if you are in the Original Medicare Plan. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

BENEFITS
The money or services provided by an insurance policy. In a health plan, benefits are the health care you get.

BENEFITS DESCRIPTION (PLAN)
The scope, terms and/or conditions of coverage including any limitations (s) associated with the plan provision of the service.

BIOLOGICALS
Usually a drug or vaccine made from a live product and used medically to diagnose, prevent, or treat a medical condition. For example, a flu or pneumonia shot.

BOARD AND CARE HOME
A type of group living arrangement designed to meet the needs of people who cannot live on their own. These homes offer help with some personal care services.

BOARD-CERTIFIED
This means a doctor has special training in a certain area of medicine and has passed an advanced exam in that area of medicine. Both primary care doctors and specialists may be board-certified.

CAPITATION
A specified amount of money paid to a health plan or doctor. This is used to cover the cost of a health plan member's health care services for a certain length of time.

CAPED RENTAL ITEM
Durable medical equipment (like nebulizers or manual wheelchairs) that cost more than & 150, and the supplier rents it to people with Medicare more than 25 percent of the time.

CARE PLAN
A written plan for your care. It tells what services you will get to reach and keep your best physical, mental, and social well-being.

CAREGIVER
A person who helps care for someone who is ill, disabled, or aged. Some caregivers are relatives or friends who volunteer their help. Some people provide caregiving services for a cost.

CARRIER
A private company that has a contract with Medicare to pay your Medicare part B bills. (See Medicare part B.)

CASE MANAGEMENT
A process used by a doctor, nurse, or other health professional to manage your health care. Case managers make sure that you get needed services, and track your use of facilities and resources.

CATASTROPHIC ILLNESS
A very serious and costly health problem that could be life threatening or cause life-long disability. The cost of medical services alone for this type of serious illness condition could cause you financial hardship.

CATASTROPIC LIMIT
The highest amount of money you have to pay out of your pocket during a certain period of time for certain covered charges. Setting a maximum amount you will have to pay protects you.

CENTERS FOR DISEASE CONTROL AND PREVENTION
An organization that maintains several code sets included in the HIPAA standards, including the ICD-9-CM codes.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)
The federal agency that runs the Medicare program. In addition, CMS works with the States to run the Medicaid program. CMS works to make sure that the beneficiaries in these programs are able to get high quality health care.

CERTIFICATE OF MEDICAL NECESSITY
A form required by Medicare that allows you to use certain durable medical equipment prescribed by your doctor or one of the doctor's office staff.

CERTIFIED (CERTIFICATION)
This means a hospital has passed a survey done by a State government agency. Being certified is not the same as being accredited. Medicare only covers care in hospitals that are certified or accredited.

CERTIFIED NURSING ASSISTAND (CNA)
CNAs are trained and certified to help nurses by providing non-medical assistance to patients, such as help with bathing, dressing, and using the bathroom.

CIVILIAN HEALTH AND MEDICAL PROGRAM (CHAMPUS)
Run by the Department of Defense in the past CHAMPUS gave medical care to active duty members of the military, military retirees, and their eligible dependents. (This program in now called (TRICARE)

CLAIM

A claim is a request for payment for services and benefits you received. Claims are also called bills for all Part A and part B services billed through Fiscal Intermediaries. "Claim" is the word used for Part B physician/supplier services billed through the Carrier. (See Carrier; Fiscal Intermediaries; Medicare part A; Medicare part B.)

CLAIM ADUSTMENT REASON CODES

A national administrative code set that identifies the reasons for any differences, or adjustments, between the original provider charge for a claim or service and the payer's payment for it. This code set is used in the X12835 Claim Payment & Remittance Advice and the X!@837 Claim transactions, and is maintained by the Health Care Maintenance Committee.

CLAIM ATTACHMENT

Any of a variety of hardcopy forms or electronic records needed to process a claim in addition to the claim itself.

CLINICAL BREAST EXAM

An exam by your doctor/health care provider to check for breast cancer by feeling and looking at your breasts. This exam is not the same as a mammogram and is usually done in the doctor's office during your Pap test and pelvic exam.

CLINICAL PERFORMANCE MEASURE

This is a method or instrument to estimate or monitor the extent to which the actions of a health care practitioner or provider conform to practice guidelines, medial review criteria, or standards of quality.

CLINICAL PRACTICE GUIDELINES

Reports written by experts who have carefully studied whether a treatment works and which patients are most likely to be helped by it.

CLINICAL TRIALS

Clinical trials are one of the final stages of a long and careful research process to help patients live longer, healthier lives. The help doctors and researchers find better ways to prevent, diagnose, or treat diseases. Clinical trials test new types of medical care, like how well a new cancer drug works. The trials help doctors and researchers see if the new care works and if it is safe. They may also be used to compare different treatments for the same condition to see which treatment is better, or to test new uses for treatments already in use.

COGNITIVE IMPAIRMENT

A breakdown in a person's mental state that may affect a person's moods, fears, anxieties, and ability to think clearly.

COHORT

A population group that shares a common property, characteristic, or event, such as a year of birth, or year of marriage. The most common one is the birth cohort; a group of individuals born within a defined time period, usually a calendar year or a five-year interval.

COINSURANCE (MEDICARE PRIVATE FEE-FOR-SERVICE PLAN)

The percentage of the Private Fee-for-Service Plan charge for services that you may have to pay after you pay any plan deductibles. In a Private Fee-for-Service Plan, the coinsurance payment is a percentage of the cost of the service (like 20%).

COINSURANCE (OUTPATIENT PROSPECTIVE PAYMENT SYSTEM)

The percentage of the Medicare payment rate or a hospital's billed charge that you have to pay after you pay the deductible for Medicare Part B services.

COMMUNITY MENTAL HEALTH CENTER
A facility that provides the following services:
Outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharge from inpatient treatment at a mental health facility; 24 hour a day emergency care services; Day treatment, other than partial hospitalization services, or psychosocial rehabilitation services; Screening for patients considered for admission to State mental health facilities to determine the appropriateness of such admission; and Consultation and education services.

COMPLAINT (OF FRAUD OR ABUSE)
A statement, oral or written, alleging that a provider or beneficiary received a Medicare benefit of monetary value, directly or indirectly, overtly or covertly, in cash or in kind, to which he or she is not entitled under current Medicare law, regulations, or policy. Included are allegations of misrepresentation and violations of Medicare requirements applicable to persons or entities that bill for covered items and services.

Comprehensive Outpatient Rehabilitation Facility (CORF)
A facility that provides a variety of services including physicians' services, physical therapy, social or psychological services, and outpatient rehabilitation.

CONDITIONAL PAYMENT
A payment made by Medicare for services for which another payer is responsible.

CONSENT AND AUTHORIZATION (BASIC RULE)
A covered entity may use or disclose PHI only:
With the consent of the individual for treatment, payment, or health care operations;
With the authorization of the individual for all other uses or disclosures;
As permitted under this rule for certain public policy purposes.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)
A law that lets some people keep their employer group health plan coverage for a period of time after: the death of your spouse, losing your job, having your working hours reduced, leaving your job voluntarily, or getting a divorce. You may have to pay both your share and the employer's share of the premium. Generally, you also have to pay an administrative fee.

CONTINUING CARE RETIREMENT COMMUNITY (CCRC)
A housing community that provides different levels of care based on what each resident needs over time. This is sometimes called "life care" and can range from independent living in an apartment to assisted living to full-time care in a nursing home. Residents move from one setting to another based on their needs but continue to live as part of the community. Care in CCRCs is usually expensive. Generally, CCRSs require a large payment before you move in and charge monthly fees.

CONTRACTOR
An entity that has an agreement with CMS or another funding agency to perform a project.

COORDINATION OF BENEFITS
A program that determines which plan or insurance policy will pay first if two health plans or insurance policies cover the same benefits. If one of the plans is a Medicare health plan, Federal law may decide who pays first.

COORDINATION PERIOD
A period of time when your employer group health plan will pay first on our health care bills and Medicare will pay second. If your employer group health plan doesn't pay 100% of your health care bills during the coordination period, Medicare may pay the remaining costs.

COST SHARING
The cost for medical care that you pay yourself like a copayment, coinsurance, or deductible. (See Coinsurance; Co-payment;
Deductible.)

COST-BASED HEALTH MAINTENANCE ORGANIZATION
A type of managed care organization that will pay for all of the enrollees' members' Medicare costs in return for a monthly premium, plus any applicable deductible or co-payment. The HMO will pay for all hospital costs (generally referred to as Part A) and physician costs (generally referred to as Part B) that it has arranged for and ordered. Like a health care prepayment plan (HCPP), except for out-of-area emergency services, if a Medicare member' enrollee chooses to obtain services that have hot been arranged for by the HMO, he/she is liable for any applicable deductible and co-insurance amounts, with the balance to be paid by the regional Medicare intermediary and/or carrier.

COVERED BENEFIT
A health service or item that is included in your health plan, and that is paid for either partially or fully.

COVERED CHARGES
Services or benefits for which a health plan makes either partial or full payment.

CREDITABLE COVERAGE
Any previous health insurance coverage that can be used to shorten the pre-existing condition waiting period. (See Pre-existing Conditions)

CRITERIA
The expected levels of achievement or achievement or specifications against which performance can be assessed.

CRITICAL ACCESS HOSPITAL
A small facility that gives limited outpatient and inpatient hospital services to people in rural areas.

CUSTODIAL CARE
Non-skilled, personal care, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include care that most people do themselves, like using eye drops. In most cases, Medicare doesn't pay for custodial care.

CUSTODIAL CARE FACILITY
A facility, which provides room, board, and other personal assistance services, generally on a long-term basis and which does not include a medical component.

CUSTODIAN
The person responsible for the security and safeguard of CMS data for the duration of the project.

DATE OF FILING AND DATE OF SUBMISSION
The date on the return receipt of "return receipt requested" mail, unless otherwise defined.

DEDUCTIBLE (MEDICARE)
The amount you must pay for health care before Medicare begins to pay, either for each benefit period for Part A, or each year for Part B. These amounts can change every year. (See Benefit Period; Medicare Part A; Medicare Part B)

DEEMED
Providers are deemed when they know, before providing services that you are in a Private Fee-for -Service Plan, and they agree to give you care. Providers that are deemed agree to follow your plan's terms and conditions of payment for the services that you get.

DEFICIENCY (NURSING HOME)
A finding that a nursing home failed to meet one or more federal or state requirements.

DEMOGRAPHIC DATA
Data that describe the characteristics of enrollee populations within a managed care entity. Demographic data include but are not limited to age, sex, race/ethnicity, and primary language.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DHHS administers many of the "social" programs at the Federal level dealing with the health and welfare of the citizens of the United States. (It is the "parent" of CMS.)

DESIGNATED CODE SET
A medical code set or an administrative code set that is required to be used by the adopted implementation specification for a standard transaction.

DETERMINATION
A decision made to either pay in full, pay in part, or deny a claim.

DIABETIC DURABLE MEDICAL EQUIPMENT
Purchased or rented ambulatory items, such as glucose meters and insulin infusion pumps, prescribed by a health care provider for use in managing a patient's diabetes, as covered by Medicare.

DIAGNOSIS
The name for the health problem that you have.

DIAGNOSIS CODE

The first of these codes is the ICD-9-CM diagnosis code describing the principal diagnosis (i.e. the condition established after study to be chiefly responsible for causing this hospitalization). The remaining codes are the ICD-0-CM diagnosis codes corresponding to additional conditions that coexisted at the time of admission, or developed subsequently, and which had an effect on the treatment received or the length of stay.

DIAGNOSIS-RELATED GROUPS

A classification system that groups patients according to diagnosis, type of treatment, age, and other relevant criteria. Under the prospective payment system, hospitals are paid a set fee for treating patients in a single DRG category, regardless of the actual cost of the care for the individual.

DIALYSIS

Dialysis is a treatment that cleans your blood when your kidneys don't work. It gets rid of harmful wastes and extra salt and fluids that build up in your body. It also helps control blood pressure and helps your body keep the right amount of fluids. Dialysis treatments help you feel better and live longer, but they are not a cure for permanent kidney failure.

DIALYSIS CENTER (RENAL)

A hospital unit that is approved to furnish the full spectrum of diagnostic, therapeutic, and rehabilitative services required for the care of the ESRD dialysis patients (including inpatient dialysis) furnished directly or under arrangement.

DIALYSIS STATION

A portion of the dialysis patient treatment area which accommodates the equipment necessary to provide a hemodialysis or peritoneal dialysis treatment. This station must have sufficient area to house a chair or bed, the dialysis equipment, and emergency equipment if needed. Provision for privacy is ordinarily supplied by drapes or screens.

DIGITAL IMAGING AND COMMUNICATIONS IN MEDICINE
A standard for communicating images such as x-rays, in a digitized form. This standard could become part of the HIPAA claim attachments standards.

DISABILITY
For social Security purposes, the inability to engage in substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or to last for a continuous period of not less than 12 months. Special rules apply for workers aged 55 or older whose disability is based on blindness. The law generally requires that a person be disabled continuously for 5 months before he or she can qualify for a disabled worker cash benefit. An additional 24 months is necessary to qualify for Medicare.

DISABILITY INSURANCE
See "Old-Age, Survivors, and Disability Insurance (OASDI)."

DISABLED ENROLLEE

An individual under age 65 who has been entitled to disability benefits under Title ll of the Social Security Act or the Railroad Retirement system for at least 2 years and who is enrolled in the SMI program.

DISCHARGE PLANNING
A process used to decide what a patient needs for a smooth move from one level of care to another. This is done by a social worker or other health care professional. It includes moves from a hospital to a nursing home or to home care. Discharge planning may also include the services of home health agencies to help with the patient's home care.

DISCLOSURE
Release or divulgence of information by an entity to persons or organizations outside of that entity.

DISCLOSURE HISTORY
Under HIPAA this is a list of any entities that have received personally identifiable health care information for uses unrelated to treatment and payment.

DISCOUNT DRUG LIST
A list of certain drugs and their proper dosages. The discount drug list includes the drugs the company will discount.

DISENROLL
Ending your health care coverage with a health plan.

DISPROPORTIONATE SHARE HOSPITAL
A hospital with a disproportionately large share of low-income patients. Under Medicaid, States augment payment to these hospitals. Medicare inpatient hospital payments are also adjusted for this added burden.

DRG CODING
The DRG categories used by hospitals on discharge billing. See also "Diagnosis-related groups (DRGs)."

DRUG TIERS
Drug tiers are definable by the plan. The option "tier" was introduced in the PBP to allow plans the ability to group different drug types together (i.e., Generic, Brand, Preferred Brand). In this regard, tiers could be used to describe drug groups that are based on classes of drugs. If the "tier" option is utilized, plans should provide further clarification on the drug type(s) covered under the tier in the PBP notes section(s). This option was designed to afford users additional flexibility in defining the prescription drug benefit.

DUAL ELIGIBLES
Persons who are entitled to Medicare (Part A and/or Part B) and who are also eligible for Medicaid.

DURABLE MEDICAL EQUIPMENT
Purchased or rented items such as hospital beds, iron lungs, oxygen equipment, seat lift equipment, wheelchairs, and other medically necessary equipment prescribed by a health care provider to be used in a patient's home which are covered by Medicare.

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER (DMERC)
A private company that contracts with Medicare to pay bills for durable medical equipment.

DURABLE POWER OF ATTORNEY
A legal document that enables you to designate another person, called the attorney-in-fact, to act on your behalf, in the event you become disabled or incapacitated.

ELECTION PERIODS
Time when an eligible person may choose to join or leave the Original Medicare Plan or a Medicare Advantage plan. There are four types of election periods in which you may join and leave Medicare health plans: Annual Election Period, Initial Coverage Election Period, Special Election Period, and Open Enrollment Period.

ELIGIBILITY
Refers to the process whereby an individual is determined to be eligible for health care coverage through the Medicaid program. Eligibility is determined by the State. Eligibility data are collected
and managed by the State or by its Fiscal Agent. In some managed care waiver programs, eligibility records are updated by an Enrollment Broker, who assists the individual in choosing a managed care plan to enroll in.

ELIGIBILITY / MEDICARE PART A

You are eligible for premium-free (no-cost) Medicare Part A (Hospital Insurance) if:

- If you are 65 or older and are receiving, or are eligible for, retirement benefits from Social Security or Railroad Retirement Board
  You are under 65 and you have received Railroad Retirement disability benefits for the prescribed time and you meet the Social Security Act disability requirements
- You or your spouse had Medicare-covered government employment
- You are under 65 and have End-Stage Renal Disease (ESRD)

If you are not eligible for premium-free Medicare Part A, you can buy Part A by paying a monthly premium if:

- You are age 65 or older and,
- You are enrolled in Part B
- You are a resident of the United States, and are either a citizen or an alien lawfully admitted for permanent residence who has lived in the United States continuously during the 5 years immediately before the month in which you apply.

ELIGIBILITY / MEDICARE PART B

You are automatically eligible for Part B if you are eligible for
Premium- free Part A. You are also eligible for Part B if you are not eligible for premium-free part A, but are age 65 or older AND a resident of the United States or a citizen or an alien lawfully admitted for permanent residence. In this case, you must have lived in the United States continuously during the 5 years immediately before the month during which you enroll in Part B.

EMERGENCY CARE

Care given for a medical emergency when you believe that your health is in serious danger when every second counts.

EMERGENCY ROOM (HOSPITAL)
A portion of the hospital where emergency diagnosis and treatment of illness or injury is provided.

EMPLOYEE
For purposes of the Medicare Secondary Payer (MSP) provisions, an employee is an individual who works for an employer, whether on a full-or part-time basis, and receives payment for his/her work.

EMPLOYER
Individuals and organizations engaged in a trade or business, plus entities exempt from income tax such as religious, charitable, and educational institutions, the governments of the United States, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern, Mariana Islands, and the District of Columbia, and the agencies, instrumentalities, and political subdivisions of these governments.

EMPLOYER GROUP HEALTH PLAN (GHP)
A GHP is a health plan that gives health coverage to employees, former employees, and their families, and is from an employer or employee organization.

END-STAGE RENAL DISEASE (ESRD)
Permanent kidney failure. That stage of renal impairment that appears irreversible and permanent, and requires a regular course of dialysis or kidney transplantation to maintain life.

ENROLLMENT PERIOD
A certain period of time when you can join a Medicare health plan if it is open and accepting new Medicare members. If a health plan chooses to be open, it must allow all eligible people with Medicare to join.

ENROLLMENT / PART A

There are four periods during which you can enroll in premium Part A:
Initial Enrollment Period (IEP), General Enrollment Period (GEP), and Special Enrollment Period (SEP).
Initial Enrollment Period: The IEP is the first chance you have to enroll in premium Part A. Your IEP starts 3 months before you first meet all the eligibility requirements for Medicare and continues for 7months.

General Enrollment Period: January 1 through March 31 of each year. Your premium Part A coverage is effective July 1 after the GEP in which you enroll.

Special Enrollment Period: The SEP is for people who did not take premium Part A during their IEP because you or your spouse currently work and have group health plan coverage through your current employer or union. You can sign up for premium Part A at any time you are covered under the Group Health Plan based on current employment. If the employment or group health coverage ends, you have 8 months to sign up, whichever comes first.

ESRD ELIGIBILITY REQUIREMENTS

To qualify for Medicare under the renal provision, a person must have ESRD and either be entitled to a monthly insurance benefit under Title II of the Act (or an annuity under the Railroad Retirement Act), be fully or currently insured under Social Security (railroad work may count), or be the spouse or dependent child of a person who meets at least one of the two last requirements. There is no minimum age eligibility under the renal disease provision. An Application for Health Insurance Benefits Under Medicare for Individuals with Chronic Renal Disease, Form HCFA-43 (effective October 1, 1978) must be filed.

EXCESS CHARGES

If you are in the Original Medicare Plan, this is the difference between a doctor's or other health care provider's actual charge (which may be limited by Medicare of the state) and the Medicare-approved payment amount

EXCLUSIONS (MEDICARE)
Items or services that Medicare does not cover, such as most prescription drugs, long-term care, and custodial care in a nursing or private home.

EXPEDITED APPEAL
A Medicare Advantage plan organization's second look at whether it will provide a health service. A beneficiary may receive a fast decision within 72 hours when life, health or ability to regain function may be jeopardized.

EXTENDED CARE SERVICES
In the context of this report, an alternate name for "skilled nursing facility services".

EXTERNAL QUALITY REVIEW ORGANIZATION
Is the organization with which the State contracts to evaluate the care provided to Medicaid managed eligible's. Typically the EQRO is a peer review organization. It may conduct focused medial record reviews (i.e. Reviews targeted at a particular clinical condition) or broader analyses on quality. While most EQRO contractors rely on medical records as the primary source of information, they may also use eligibility data and claims/encounter data to conduct specific analyses.

FACILITY CHARGE
Some plans may vary cost shares for services based on place of treatment; in effect, charging a cost for the facility in which the service is received.

FEDERALLY QUALIFIED HEALTH CENTER (FQHC)
Health centers that have been approved by the government for a program to give low cost health care. Medicare pays for some health services in FQHCs that are not usually covered, like preventive care. FQHCs include community health centers, tribal health clinics, migrant health services, and health centers for the homeless.

FEE SCHEDULE
A complete listing of fees used by health plans to pay doctors or other providers.

FEE-FOR-SERVICES
A plan or PCCM is paid for providing services to enrollees solely through fee-for-services payments plus in most cases, a case management fee.

FISCAL INTERMEDIARY
A private company that has a contract with Medicare to pay Part A and some Part B bills. (Also called “Intermediary”.)

FORMULARY
A list of certain drugs and their proper doses. In some Medicare health plans, doctors must order or use only drugs listed on the health plan’s formulary.

FORMULARY DRUGS
Listing of prescription medications which are approved for use and/or coverage by the plan and which will be dispended through participating pharmacies to covered enrollees.

FRAUD
The intentional deception or misrepresentation that an individual knows, or should know, to be false, or does not believe to be true, and makes, knowing the deception could result in some unauthorized benefit to himself or some other person(s).

FRAUD AND ABUSE
Fraud: To purposely bill for services that were never given or to bill for a service that has a higher reimbursement than the service produced. Abuse: Payment for items or services that are billed by mistake by providers, but should not be paid for by Medicare. This is not the same as fraud.

FREE LOOK (MEDIGAP POLICY)

A period of time (usually 30 days) when you can try out a Medigap policy. During this time, if you change your mind about keeping the policy, it can be cancelled. If you cancel, you will get your money back.

GAPS

The costs or services that are not covered under the Original Medicare Plan.

GATEKEEPER

In a managed care plan, this is another name for the primary care doctor. This doctor gives you basic medical services and coordinates proper medical care and referrals.

GENERAL ENROLLMENT PERIOD (GEP)

The General Enrollment Period is January 1 through march 31 of each year. If you enroll in Premium Part A or Part B during the General Enrollment Period, your coverage starts on July 1.

GENERIC DRUG

A prescription drug that has the same active ingredient formula as a brand name drug. Generic drugs usually cost less than brand name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and effective as brand name drugs.

GRIEVANCE

A complaint about the way your Medicare health plan is giving care. For example, you may file a grievance if you have a problem calling the plan or if you are unhappy with the way a staff person at the plan has behaved toward you. A grievance is not the way to deal with a complaint about a treatment decision or a service that is not covered (see Appeal).

GRIEVANCES AND COMPLAINTS

Information about grievances and complaints submitted to the health plan.

GROUP HEALTH PLAN
A health plan that provides health coverage to employees, former employees and their families, and is supported by an employer or employee organization.

GROUP OR NETWORK HMO
A health plan that contracts with group practices of doctors to give services in one or more places.

GUARANTEED ISSUE TIGHTS (ALSO CALLED "MEDIGAP PROTECTIONS")
Rights you have in certain situations when insurance companies are required by law to sell or offer you a Medigap policy. In these situations, an insurance company can't deny you insurance coverage or place conditions on a policy, must cover you for all pre-existing conditions, and can't change you more for a policy because of past or present health problems.

GUARANTEED RENEWABLE
A right you have that requires your insurance company to automatically renew or continue your Medigap policy, unless you make untrue statements to the insurance company, commit fraud or don't pay your premiums.

HEALTH CARE QUALITY IMPROVEMENT PROGRAM
HCQIP is a program, which supports the mission of CMS to assure health care security for beneficiaries. The mission of the HCQIP is to promote the quality, effectiveness, and efficiency of services to Medicare beneficiaries by strengthening the community of those committed to improving quality, monitoring and improving quality of care, communicating with beneficiaries and health care providers, practitioners, and beneficiaries from poor care, and strengthening the infrastructure.

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA)

A law passed in 1996 which is also sometimes called the "Kassebaum-Kennedy" law. This law expands your health care coverage if you have lost your job, or if you move from one job to another, HIPAA protects you and your family if you have: pre-existing medical conditions, and/or problems getting health coverage, and you think it is based on past or present health. HIPAA also:

Limits how companies can use your pre-existing medical conditions to keep you from getting health insurance coverage;

Usually gives you credit for health coverage you have had in the past.

May give you special help with group health coverage when you lose coverage, or have a new dependent.

Generally guarantees your right to renew your health coverage.

HIPAA does not replace the states' roles as primary regulators of insurance.

HEALTH MAINTENANCE ORGANIZATIONS (HMO)

A type of Medicare managed care plan where a group of doctors, hospitals, and other health care providers agree to give health care to Medicare beneficiaries for a set amount of money from Medicare every month. You usually must get your care from the providers in the plan.

HEARING

A procedure that gives a dissatisfied claimant an opportunity to present reasons for the dissatisfaction and to receive a new determination based on the record developed at the hearing. Hearings are provided for in 1842 (b) (3) (C) of the Act.

HOME AND COMMUNITY-BASED SERVICE WAIVER PROGRAMS (HCBS)

The HCBS programs offer different choices to some people with Medicaid. If you qualify, you will get care in your home and community so you can stay independent and close to your family and friends. HCBS programs help the elderly and disabled, mentally retarded, developmentally disabled, and certain other disabled adults. These programs give quality and low-cost services.

HOME HEALTH AGENCY
An organization that gives home care services, like skilled nursing care, physical therapy, occupational therapy, speech therapy, and personal care by home health aides.

HOME HEALTH CARE
Limited part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speed-language therapy, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.

HOMEBOUND
Normally unable to leave home unassisted. To be homebound means that leaving home takes considerable and taxing effort. A person may leave home for a medical treatment or short, infrequent absences for non-medical reasons, such as a trip to the barber or to attend religious service. A need for adult day care doesn't keep you from getting home health care.

HOSPICE
Hospice is a special way of caring for people who are terminally ill, and for their family. This care includes physical care and counseling. Hospice care is covered under Medicare part A (Hospital Insurance).

HOSPICE CARE
A special way of caring for people who are terminally ill, and for their family. This care includes physical care and counseling. Hospice is covered under Medicare Part A (Hospital Insurance).

HOSPITAL COINSURANCE
For the 61st through 90th day of hospitalization in a benefit period, a daily amount for which the beneficiary is responsible, equal to

one-fourth of the inpatient hospital deductible; for lifetime, reserve days, a daily amount for which the beneficiary is responsible, equal to one-half of the inpatient hospital deductible (see “Lifetime reserve days”).

HOSPITAL INDEMNITY INSURANCE
This kind of insurance pays a certain cash amount for each day you are in the hospital up to a certain number of days. Indemnity insurance doesn’t fill gaps in your Medicare coverage.

HOSPITAL INSURANCE
The Medicare program that covers specified inpatient hospital services, post-hospital skilled nursing care, home health services, and hospice care for aged and disabled individuals who meet the eligibility requirements. Also known as Medicare Part A.

HOSPITAL INSURANCE PART A
The part of Medicare that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

HOSPITALIST
A doctor who primarily takes care of patients when they are in the hospital. This doctor will take over your care from your primary doctor when you are in the hospital, keep your primary doctor informed about your progress, and will return you to the care of your primary doctor when you leave the hospital.

IMMUNOSUPPRESSIVE DRUGS
Transplant drugs used to reduce the risk of rejecting the new kidney after transplant. Transplant patients will need to take these drugs for the rest of their lives.

INITIAL COVERAGE ELECTION PERIOD
The 3 months immediately before are entitled to Medicare Part A and enrolled in Part B. You may choose a Medicare health plan during your initial coverage Election Period. The plan must accept you unless it has reached its limit in the number of members. This limit is approved by the Centers for Medicare & Medicaid Services.

The Initial Coverage Election Period is different from the Initial Enrollment Period (IEP). (See Election Periods; Enrollment/Part A; Initial Enrollment Period (IEP)).

INITIAL ENROLLMENT PERIOD
The Initial Enrollment Period is the first chance you have to enroll in Medicare Part B. Your Enrollment Period starts three months before you first meet all the eligibility requirements for Medicare and lasts for seven months.

INPATIENT CARE
Health care that you get when you are admitted to a hospital.

INPATIENT HOSPITAL
A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and non-surgical) and rehabilitation services by or under the supervision of physicians, to patients admitted for a variety of medical conditions.

INPATIENT HOSPITAL DEDUCTIBLE
An amount of money that is deducted from the amount payable by Medicare Part A for inpatient hospital services furnished to a beneficiary during a spell of illness.

INPATIENT HOSPITAL SERVICES
These services include bed and board, nursing services, diagnostic or therapeutic services, and medical or surgical services.

INPATIENT PSYCHIATRIC FACILITY
A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a doctor.

INSOLVENCY
When a health plan has no money or other means to stay open and give health care to patients.

INTEREST
A payment for the use of money during a specified period.

INTERMEDIARY

A private company that has a contract with Medicare to pay Part A and some Part B bills.

INTERMEDIATE CARE FACILITY/MENTALLY RETARDED
A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care available in a hospital or skilled nursing facility.

INTERNIST
A doctor who finds and treats health problems in adults.

LARGE GROUP HEALTH PLAN
A group health plan that covers employees of either an employer or employee organization that has 100 or more employees.

LETTER OF REQUEST
A formal request from the requestor on organizational letterhead detailing their data needs and purposes. Additionally, if this project is federally funded a letter of Support is required from the federal Project Officer on their organizational letterhead.

LIABILITY INSURNCE
Liability insurance is insurance that protects against claims for negligence or inappropriate action or inaction, which results in injury to someone or damage to property.

LICENSED (LICENSURE)
This means a long-term care facility has met certain standards set by a State or local government agency.

LIFETIME RESERVE DAYS
In the Original Medicare Plan, 60 days that Medicare will pay for when you are in a hospital more than 90 days during a benefit period. These 60 reserve days can be

used only once during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a coinsurance.

LIMITING CHARGE

In the Original Medicare Plan, the highest amount of money you can be charged for a covered service by doctors and other health care suppliers who don't accept assignment. The limiting charge is 15% over Medicare's approved amount. The limiting charge only applies to certain services and doesn't apply to supplies or equipment.

LIVING WILLS

A legal document also known as a medical directive or advance directive. It states your wishes regarding life-support or other medical treatment in certain other circumstances, usually when death is imminent.

LONG-TERM CARE

A variety of services that help people with health or personal needs and activities of daily living over a period of time. Long-term care can be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities. Most long-term care is custodial care. Medicare doesn't pay for this type of care if this is the only kind of care you need.

LONG-TERM CARE INSURANCE

A private insurance policy to help pay for some long-term medical and non-medical care, like help with activities of daily living. Because Medicare generally does not pay for long-term care, this type of insurance policy may help provide coverage for long-term care that you may need in the future. Some long-term care insurance policies offer tax benefits; these are called "Tax-Qualified Policies".

LONG-TERM CARE OMBUDSMAN

An advocate (supporter) for nursing home and assisted living facility residents who works to resolve problems between residents and nursing homes or assisted living facilities.

MA PLAN

Health benefits coverage offered under a policy or contract offered by a Medicare Advantage Organization under which a specific set of health benefits are offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area of the MA plan. See 42 C.F.R. ~422.2 An MA plan may be a coordinated care plan (with or without point of service options), a combination of an MA medical savings account (MSA) plan and a contribution into an MA MSA established in accordance with 42 CFR part 422.262, or an MA private fee-for-service plan. See 42 C.F.R ~422.4(a).

MANAGED CARE

Includes health maintenance Organizations (HMO), Competitive Medical Plans (CMP), and other plans that provide health services on a prepayment basis, which is based either on cost or risk, depending on the type of contract they have with Medicare.

MANAGED CARE ORGANIZATION

Managed Care Organizations are entities that serve Medicare or Medicaid beneficiaries on a risk basis through a network of employed or affiliated providers. Stands for Managed Care Organization. The term generally includes HMOs, PPOs, and Point of Service plans. In the Medicaid world, other organizations may set up managed care programs to respond to Medicaid managed care. These organizations include Federally Qualified Health Centers, integrated delivery systems, and public health clinics. It's a health maintenance organization, an eligible organization with a contract under ~1876 or a Medicare-Choice organization, a provider-sponsored organization, or any other private or public organization, which meets the requirements of ~1902 (w) to provide comprehensive services.

MANAGED CARE PLAN

In most managed care plans, you can only go to doctors, specialists, or hospitals on the plan's list except in an emergency. Plans must cover all Medicare part A and part B health care. Some managed care plans cover extra benefits, like extra days in the

hospital. In most cases, a type of Medicare Advantage Plan that is available in some areas of the country. Your costs may be lower than in the Original Medicare Plan.

MANAGED CARE PLAN WITH A POINT OF SERCIVE OPTION (POS)
A managed care plan that lets you use doctors and hospitals outside the plan for an additional cost. (See Medicare Managed Care Plan)

MASS IMMUNIZATION CENTER
A location where providers administer pneumococcal pneumonia and influenza virus vaccination and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as a public health center, pharmacy, or a mall but may include a physician's office setting. (4408.8, Part 3 of MCM).

MAXIMUM ENROLLEE OUT-OF-POCKET COSTS
The beneficiary's maximum dollar liability amount for a specified period.

MAXIMUM PLAN BENEFIT COVERAGE
The maximum dollar amount per period that a plan will insure. This is only applicable for service categories where there are enhanced benefits being offered by the plan, because Medicare coverage does not allow a Maximum Plan Benefit Coverage expenditure limit.

MEDICAID
A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you quality for both Medicare and Medicaid.

MEDICAL INSURANCE (PART B)
Medicare medical insurance that helps pay for doctor' services, outpatient hospital care, durable medical equipment, and some medical services that aren't covered b Part A.

MEDICAL REVIEW/UTILIZATION REVIEW

Contractor reviews of Medicare claims to ensure that the service was necessary and appropriate.

MEDICAL UNDERWRITING
The process that an insurance company uses to decide, based on your medical history, whether or not to take your application for insurance, whether or not to add a waiting period for pre-existing conditions (if your State law allows it), and how much to charge you for that insurance.

MEDICALLY NECESSARY
Services or supplies that: are proper and needed for the diagnosis or treatment of our medical condition, are provided for the diagnosis, direct care, and treatment of your medical condition, meet the standards of good medical practice in the local area, and aren't mainly for the convenience of you or your doctor.

MEDICARE
The federal health insurance program for: people 65 years of age or older, certain younger people with disabilities, and people with End-Stage-Renal Disease) permanent kidney failure with dialysis or a transplant, sometimes called ESRD).

MEDICARE ADVANTAGE PLAN
A Medicare program that gives you more choices among health plans. Everyone who has Medicare parts A and B is eligible, except those who have End-Stage Renal Disease (unless certain exceptions apply). Medicare Advantage Plans used to be called Medicare + Choice Plans.

MEDICARE BENEFITS
Health insurance available under Medicare Part A and Part B through the traditional fee-for-service payment system.

MEDICARE BENEFITS NOTICE

A notice you get after your doctor files a claim for Part A services in the Original Medicare Plan. It says what the provider billed for, the Medicare-approved amount, how much Medicare paid, and what you must pay. You might also get an Explanation of Medicare Benefits (EOMB) for Part B services or a Medicare Summary Notice (MSN). (See Explanation of Medicare Benefits; Medicare Summary Notice.)

MEDICARE CARRIER

A private company that contracts with Medicare to pay Part B bills.

MEDICARE CONTRACTOR

A Medicare Part A Fiscal Intermediary (institutional), a Medicare Part B Carrier (professional), or a Medicare Durable Medical Equipment Regional Carrier (DMERC).

MEDICARE COORDINATION OF BENEFITS CONTRACTOR

A Medicare contractor who collects and manages information on other types of insurance or coverage that pays before Medicare. Some examples of other types of insurance or coverage are: Group health Coverage, Retiree Coverage, Workers' Compensation, No-fault or Liability insurance, Veterans' benefits, TRICARE, Federal Black Lung Program, and COBRA.

MEDICARE COVERAGE

Made up of two parts: Hospital Insurance (Part A) and Medical Insurance (Part B). (See Medicare part A (Hospital Insurance); Medicare Part B (Medical Insurance).)

MEDICARE DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER

A Medicare contractor responsible for administering Durable Medical Equipment (DME) benefits for a region.

MEDICARE HANDBOOK

The Medicare handbook provides information on such things as how to file a claim and what type of care is covered under the Medicare program. This handbook is given to all beneficiaries when first enrolled in the program.

MEDICARE MANAGED CARE PLAN

A type of Medicare Advantage Plan that is available in some areas of the country. In most managed care plans, you can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare part A and Part B health care. Some managed care plans cover extras, like prescription drugs. Your costs may be lower than in the Original Medicare Plan.

MEDICARE MEDICAL SAVINGS ACCOUNT PLAN (MSA)

A Medicare health plan option made up of two parts. One part is a Medicare MSA Health Insurance Policy with a high deductible. The other art is a special savings account where Medicare deposits money to help you pay your medical bills.

MEDICARE PART A (HOSPITAL INSURANCE)

Hospital insurance that pays for inpatient stays, care in a skilled nursing facility, hospice care, and some home health care.

MEDICARE PART A FISCAL INTERMEDIARY

A Medicare contractor that administers the Medicare Part A (institutional) benefits for a given region.

MEDICARE PART B (MEDICAL INSURANCE)

Medicare medical insurance that helps pay for doctors' services, outpatient hospital care, durable medical equipment, and some medical services that aren't covered by Part A.

MEDICARE PART B CARRIER

A Medicare contractor that administers the Medicare Part B (Professional) benefits for a give region.

MEDICARE PREFERRED PROVIDER ORGANIZATION (PPO) PLAN
A type of Medicare Advantage Plan in which you use doctors, hospitals, and providers that belong to the network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

MEDICARE PREMIUM COLLECTION CENTER (MPCC)
The contractor that handles all Medicare direct billing payments for direct billed beneficiaries. MPCC is located in Pittsburgh, Pennsylvania.

MEDICARE PRIVATE FEE-FOR-SERVICE PLAN
A type of Medicare Advantage plan in which you may go to any Medicare-approved doctor or hospital that accepts the plan's payment. The insurance plan, rather than the Medicare program, decides how much it will pay and what you pay for the services you will get. You may pay more or less for Medicare-covered benefits. You may have extra benefits the Original Medicare Plan doesn't cover.

MEDICARE SAVINGS PROGRAM
Medicaid programs that help pay some or all Medicare premiums and deductibles.

MEDICARE SAVINGS PROGRAMS
There are programs that help millions of people with Medicare save money each year. States have programs for people with limited incomes and resources that pay Medicare premiums. Some programs may also pay Medicare deductibles and coinsurance. You can apply for these programs if: You have Medicare Part A (Hospital Insurance). (If you are eligible for Medicare Part A but don't think you can afford it, there is a program that may pay the Medicare part A premium for you), you are an individual with resources of $4,00 or less, or are a couple with resources of $6,ooo or less. Resources include money in a savings or checking account, stocks, or bonds and you are an individual with limited monthly income.

MEDICARE SECONDARY PAYER
Any situation where another payer or insurer pays your medical bills before Medicare.

MEDICARE SELECT
A type of Medigap policy that may require you to use hospitals and, in some cases, doctors within its network to be eligible for full benefits.

MEDICARE SUMMARY NOTICE (MSN)
A notice you get after the doctor or provider files a claim for part A and Part B services in the Original Medicare Plan. It explains what the provider billed for, the Medicare-approved amount, how much Medicare paid, and what you must pay.

MEDICARE SUPLEMENT INSURANCE
Medicare supplement insurance is a Medigap policy. It is sold by private companies to fill "gaps" in Original Medicare Plan coverage. Except in Minnesota, Massachusetts, and Wisconsin, there are 12 standardized policies labeled Plan SA through Plan L. Medigap policies only work with the Original Medicare Plan. (See Gaps and Medigap Policy.)

MEDICARE APPROVED AMOUNT
In the Original Medicare Plan, this is the Medicare payment amount for an item or service. This is the amount a doctor or supplier is paid by Medicare and you for a service or supply. It may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes called the "Approved Charge".

MEDIGAP POLICY
A Medicare supplement insurance policy sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Except in Massachusetts, Minnesota and Wisconsin, there are 12 standardized plans labeled Plan A through Plan L. Medigap policies only work with the Original Medicare Plan (See Gaps.)

MILITARY TREATMENT FACILITY
A medical facility operated by one or more of the Uniformed Services. A Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Services (USPHS) facilities now designated as Uniformed Service treatment Facilities (USTF).

MULTI-EMPLOYER GROUP HEALTH PLAN (MULTIPLE EMPLOYER PLAN)
A group health plan that is sponsored jointly by two or more employers or by employers and employee organizations.

NATIONAL HEALTH INFORMATION INFRASTRUCTURE
This is a healthcare-specific lane on the Information Superhighway, as described in the national Information Infrastructure (NII) initiative. Conceptually, this includes the HIPPA A/S initiatives.

NEBULIZERS
Equipment to give medicine in a mist form to your lungs.

NEGLECT
When care takers do not give a person they care for the goods or services needed to avoid harm or illness.

NETWORK
A group of doctors, hospitals, pharmacies, and other health care experts hired by a health plan to take care of its members.

NO-FAULT INSURANCE
No-fault insurance is insurance that pays for health care services resulting from injury to you or damage to your property regardless of who is at fault for causing the accident.

NON-COVERED SERVICE
The service:
Does not meet the requirements of a Medicare benefit category
Is statutorily excluded from coverage on ground other than 1862 (a) (1) or
Is not reasonable and necessary under 1862 (a) (1).

NON-FORMULARY DRUGS
Drugs not on a plan-approved list.

NONPARTICIPATING PHYSICIAN
A doctor or supplier who does not accept assignment on all Medicare claims.

NURSE PRACTITONER
A nurse who has 2 or more year of advanced training and has passed a special exam. A nurse practitioner often works with a doctor and can do some of the same things a doctor does.

NURSING FACILITY
A facility which primarily provides to residents skilled nursing care and relate services for the rehabilitation of injured, disabled, or sick persons, or on a regular basis, health related care services above the level of custodial care to other than mentally retarded individuals.

NURSING HOME
A residence that provides a room, meals, and help with activities of daily living, and recreation. Generally, nursing home residents have physical or mental problems that keep them from living on their own. They usually require daily assistance.

OCCUPATIONAL THERAPY
Services given to help you return to usual activities (such as bathing, preparing meals, housekeeping), after illness.

OFFICE
Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE
The social Security programs that pay for (1) monthly cash benefits to retired-worker (old-age) beneficiaries, their spouses and children, and survivors of deceased insured workers (OASI); and (2) monthly cash benefits to disabled-worker beneficiaries and their spouses and children, and for providing rehabilitation services to the disabled (DI).

OMBUDSMAN
An ombudsman is an individual who assists enrollees in resolving problems they may have with their MCO/PHP. An ombudsman is a neutral party who works with the enrollee, the MCO/PHP, and the provider (as appropriate) to resolve individual enrollee problems.

OPEN ENROLLMENT PERIOD
A one-time-only six month period when you can buy any Medigap policy you want that is sold in your state. It starts in the first month that you are covered under Medicare Part B and you are age 65 or older. During this period, you can't be denied coverage or charged more due to past or present health problems.

ORIGINA MEDICARE PLAN
A pay-per-visit health plan that lets you go to any doctor, hospital, or other health care supplier who accepts Medicare and is accepting new Medicare patients. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance). In some cases you may be charged more than the Medicare-approved amount. The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part A (Medical Insurance).

OUT OF NETWORK BENEFIT
Generally, an out-of-network benefit provides a beneficiary with the option to access plan services outside of the plans contracted network of providers. In some cases, a beneficiary's out of-pocket costs may be higher for an out-of-network benefit.

OUT-OF-POCKET COSTS
Health care costs that you must pay on your own because they are not covered by Medicare or other insurance.

OUTPATIENT CARE
Medical or surgical care that does not include an overnight hospital stay.

OUTPATIENT HOSPITAL
A portion of a hospital which provides diagnostic, therapeutic, (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. Part of the hospital providing services covered by SMI, including services in an emergency room or outpatient clinic, ambulatory surgical procedures, medical supplies such as splints, laboratory tests billed by the hospital, etc.

OUTPATIENT HOSPITAL SERVICES (MEDICARE)
Medicare or surgical care that Medicare Part B helps pay for and does not include an overnight hospital stay, including: blood transfusions, certain drugs, hospital billed laboratory tests, mental healthcare, medical supplies such as splints and casts, emergency room or outpatient clinic including same day surgery, and x-rays and other radiation services.

OUTPATIENT SERVICES
A service you get in one day (24 hours) at a hospital outpatient department or community mental health center.

PAP TEST
A test to check for cancer of the cervix, the opening to a woman's womb. It is done by removing cells from the cervix. The cells are then prepared so they can be seen under a microscope.

PART A (HOSPITAL INSURANCE)
Hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

PART A OF MEDICARE
Medicare Hospital Insurance also referred to as "HI." Part A is the hospital insurance portion of Medicare. It was established by ~1811 of Title XVIII of the Social Security Act of 1965, as amended, and covers inpatient hospital care, skilled nursing facility care, some home health agency services, and hospice care.

PART A PREMIUM
A monthly premium paid by or on behalf of individuals who wish for and are entitled to voluntary enrollment in the Medicare HI program. These individuals are those who are aged 65 and older, are uninsured for social security or railroad retirement, and do not otherwise meet the requirements for entitlement to Part A. Disabled individuals who have exhausted other entitlement are also qualified. These individuals are those not now entitled but who have been entitled under section 226(b) the Act, who continue to have the disabling impairment upon which their entitlement was based, and whose entitlement ended solely because the individuals had earnings that exceeded the substantial gainful activity amount (as defined in section 223 (d) (4) of the Act).

PART B (MEDICAL INSURANCE)
Medicare medical insurance that helps pay for doctors' services, outpatient hospital care, durable medical equipment, and some medical services that are not covered by Part A.

PART B (MEDICARE)
Medicare medical insurance that helps pay for doctors' services, outpatient hospital care, durable medical equipment, and some medical services that are not covered by Part A. (See Medical Insurance (Part B).)

PART B OF MEDICARE
Medicare Supplementary Medical Insurance also referred to as "SMI." Medicare Insurance that pays for inpatient hospital stay, care in a skilled nursing facility, home health care, and hospice care. Part B is the supplementary or "physicians" insurance portion of Medicare. It was established by 1831 of the title XVIII of the Social Security Act of 1965 as amended, and covers services of physicians/other suppliers, outpatient care, medical equipment and supplies, and other medical services not covered by the hospital insurance part of Medicare.

PHYSICIAN GROUP
A partnership, association, corporation, individual practice association (IPA), or other group that distributes income from the practice among members. An IPA is considered to be a physician group only if it is composed of individual physicians and has no subcontracts with other physician groups.

PHYSICIAN SERVICES
Services provided by an individual licensed under state law to practice medicine or osteopathy. Physician services given while in the hospital that appear on the hospital bill are not included.

PLAN OF CARE
Your doctor's written plan saying what kind of services and care you need for your health problem.

POINT OF SERVICE (POS)
An additional, mandatory supplemental, or optional supplemental benefit that allows the enrollee the option of receiving specified services outside of the plan's provider network.

POWER OF ATTORNEY

A medical power of attorney is a document that lets you appoint someone you trust to make decisions about your medical care. This type of advance directive also may be called a health care proxy, appointment of health care agent or a durable power of attorney for health care.

PRE-EXISTING CONDITION

A health problem you had before the date that a new insurance policy starts.

PREFERRED PROVIDER ORGANIZATION (PPO)

A managed care in which you use doctors, hospitals, and providers that belong to the network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

PREMIUM SURCHARGE

The standard Medicare Part B premium will go up ten percent for each full 12-month period (beginning with the first month after the end of your Initial Enrollment Period) that you could have had Medicare Part B but didn't take it. The additional premium amount is called a "premium surcharge." There will be a surcharge for Part D also.

PREVENTIVE SERVICES

Health care to keep your health or to prevent illness (for example, Pap tests, pelvic exams, flu shots, and screening mammograms).

PRIMARY CARE

A basic level of care usually given by doctors who work with general and family medicine, internal medicine (internists), pregnant women (obstetricians), and children (pediatricians). A nurse practitioner (NP), a State licensed registered nurse with special training, can also provide this basic level of health care.

PRIMARY CARE DOCTOR

A doctor who is trained to give you basic care. Your primary care doctor is the doctor you see first for most health problems. He or she makes sure that you get the care that you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare managed care plans, you must see your primary care doctor before you see any other health care provider.

PRIMARY PAYER

An insurance policy, plan, or program that pays first on a claim for medical care. This could be Medicare or other health insurance.

PRIVACY ACTOF 1974

Without the written consent of the individual, the Privacy Act prohibits release of protected information maintained in a system of records unless of 1 or the 12 disclosure provisions apply.

PRIVATE CONTRACT

A contract between you and a doctor, podiatrist, dentist, or optometrist who has decided not to offer services through the Medicare program. This doctor can't bill Medicare for any service or supplies given to you and all his/her other Medicare patients for at least 2 years. There are no limits on what you can be charged for services under a private contract. You must pay the full amount of the bill.

PRIVATE FEE-FOR-SERVICE PLAN

A type of Medicare Advantage Plan in which you may go to any Medicare-approved doctor or hospital that accepts the plan's payment. The insurance plan, rather than the Medicare program, decides how much it pays and what you pay for the services you will get. You may pay more or less for Medicare-covered benefits. You may have extra benefits the Original Medicare Plan doesn't cover.

PROCEDURE

Something done to fix a health problem or to learn more about it. for example, surgery, tests, and putting in an IV (intravenous line) are procedures.

PROGRAMS OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)

PACE combines medical, social, and long-term care services for frail people. PACE is available only in states that have chosen to offer it under Medicaid. To be eligible, you must:

- Be 55 years old, or older
- Live in the service area of the PACW program,
- Be certified as eligible for nursing home care by the appropriate state agency
- Be able to live safely in the community

The goal of PACE is to help people stay independent and live in their community as long as possible, while getting high quality care they need.

PROSPECTIVE PAYMENT SYSTEM

A method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, DRGs for inpatient hospital services).

PROVIDER

Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing medical services covered under Medicare part B. Any organization, institution, or individual that provided health care services to Medicare beneficiaries. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of services covered under Medicare Part B.

PROVIDER NETWORK

The providers with which an M+C Organization contracts or makes arrangements to furnish covered health care services to Medicare enrollees under an M+C coordinated care or network MSA plan.

PROVIDER SPONSORED ORGANIZATION (PSO)
A group of doctors, hospitals, and other health care providers that agree to give health care to Medicare beneficiaries for a set amount of money from Medicare every month. This type of managed care plan is run by the doctors and providers themselves, and not by an insurance company. (See Managed Care Plan.)

PSYCHIATRIC FACILITY (PARTIAL HOSPITALIZATION)
Partial hospitalization (location 52) is a program in which a patient attends for several hours during the day (example: 8:30-3:30) the patient is not there on a 24 hours basis.

PSYCHIATRIC RESIDENTIAL TREATMENT CENTER
A facility or distinct part of a facility for psychiatric care that provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.

QUALIFIED MEDICARE BENEFICIARY (QMB)
This is a Medicaid program for beneficiaries who need help in paying for Medicare services. The beneficiary must have Medicare Part A and limited income and resources. For those who qualify, the Medicaid program pays Medicare Part A premiums, Part B premiums, and Medicare deductibles and coinsurance amounts for Medicare services.

QUALIFYING INDIVIDUALS (1) (Qi-1S)
This is a Medicaid program for beneficiaries who need help in paying for Medicare Part B premiums. The beneficiary must have Medicare Part A and limited income and resources and not be otherwise eligible for Medicaid. For those who qualify, the Medicaid program pays full Medicare part B premiums only.

QUALIFYING INDIVIDUALS (2) (QI-2S)
This is a Medicaid program for beneficiaries who need help in paying for Medicare Part B premiums. The beneficiary must have Medicare part A and limited income and resources and not otherwise eligible for Medicaid. For those who qualify, Medicaid pays a percentage of Medicare Part B premiums only.

QUALITY ASSURANCE

The process of looking at how well a medical service is provided. The process may include formally reviewing health care given to a person, or a group of persons, locating the problem, correcting the problem, and then checking to see if what you did worked.

QUALITY IMPROVEMENT ORGANIZATION

Groups of practicing doctors and other health care experts. They are paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by: impatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Private Fee-for Service plans, and ambulatory surgical centers.

RAILROAD RETIREMENT

A federal insurance program similar to Social Security designed for workers in the railroad industry. The provisions of the Railroad Retirement Act provide for a system of coordination and financial interchange between the Railroad Retirement program and the Social Security program.

REASONABLE COST

FIs and carriers use CMS guidelines to determine reasonable costs incurred by individual providers in furnishing covered services to enrollees. Reasonable cost is based on the actual cost of providing such services, including direct and indirect cost of providers and excluding any costs that are unnecessary in the efficient delivery of services covered by the program.

RECIPIENT

An individual covered by the Medicaid program, however, now referred to as a beneficiary.

RECOUPMENT

The recovery by Medicare of any Medicare debt by reducing present or future Medicare payments and applying the amount withheld to the indebtedness.

REFERRAL
A written OK from your primary care doctor for you to see a specialist or get certain services. In many Medicare managed Care Plans, you need to get a referral before you can get care from anyone except your primary care doctor. If you don't get a referral first, the plan may not pay for your care.

REGIONAL HOME HEALTH INTERMEDIARY (RHHI)
A private company that contracts with Medicare to pay home health bills and check on the quality of home health care.

REHABILITATION
Rehabilitative services are ordered by your doctor to help you cover from an illness or injury. These services are given by nurses and physical, occupational, and speech therapists. Examples include working with a physical therapist to help you walk and with an occupational therapist to help you get dressed.

REHABILITAION (AS DISTINGUISHED FROM VOCATIONAL REHABILITATION)
A restorative process through which an individual with ESRD develops and maintains self-sufficient functioning consistent with his/her capability.

RESERVE DAYS (See Lifetime Reserve Days.)

RESPITE CARE
Temporary or periodic care provided in a nursing home, assisted living residence, or other type of long-term care program so that the usual caregiver can rest or take some time off.

RIGHTS OF INDIVIDUALS
Receive notice of information practices; See and copy own record; Request corrections; Obtain accounting of disclosures; Request restrictions and confidential communications; file complaints

RISK-BASED HEALTH MAINTENANCE ORGANIZATION/COMPETITIVE MEDICAL PLAN

A type of managed care organization. After any applicable deductible or co-payment, all of an enrollee/member's medical care costs are paid for in return for a monthly premium. However, due to the "lock-in" provision, all of the enrollee/member's services (except for out-of-area emergency services) must be arranged for by the risk-HMO. Should the Medicare enrollee/member choose to obtain service not arranged for by the plan, he/she will be liable for the costs. Neither the HMO nor the Medicare program will pay for the services from providers that are not part of the HMO's health care system/network.

RURAL HEALTH CLINIC

An outpatient facility that is primarily engaged in furnishing physicians' and other medical and health services and that meets other requirements designated to ensure the health and safety of individuals served by the clinic. The clinic must be located in a medically underserved area that is not urbanized as defined by the U.S. Bureau of Census.

SANCTIONS

Administrative remedies and actions (e.g., exclusion, Civil Monetary Penalties, etc.) available to the OIG to deal with questionable, improper, or abusive behaviors of providers under the Medicare, Medicaid, or any State health programs.

SECOND OPINIONS

This is when another doctor gives his or her view about what you have and how it should be treated.

SECONDARY PAYER

An insurance policy, plan, or program that pays second on a claim for medical care. This could be Medicare, Medicaid, or other insurance depending on the situation.

SELF-INSURED

An individual or organization that assumes the financial risk of paying for health care.

SERVICE
Medical care and items such as medical diagnosis and treatment, drugs, and biological, supplies, appliances, and equipment, medical social services, and use of hospital RPCH or SNF facilities. (42 CFR 400.202).

SERVICE AREA
The area where a health plan accepts members. For plans that require you to use their doctors and hospitals, it is also the area where services are provided. The plan may disenroll you if you move out of the plan's service area.

SERVICE AREA PRIVATE FEE-FOR-SERVICE)
The area where a Medicare Private Fee-for –Service plan accepts members.

SIDE EFFECT
A problem caused by treatment. For example, medicine you take for high blood pressure may make you feel sleepy. Most treatments have side effects.

SKILLED CARE
A type of health care given when you need skilled nursing or rehabilitation staff to manage, observe, and evaluate your care.

SKILLED NURSING CARE
A level of care that includes services that can only be performed safely and correctly by a licensed nurse) either a registered nurse or a licensed practical nurse).

SKILLED NURSING FACILITY (SNF)
A facility (which meets specific regulatory certification requirements) which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.

SKILLED NURSING FACILITY CARE

This is a level of care that requires the daily involvement of skilled nursing or rehabilitation staff. Examples of skilled nursing facility care include intravenous injections and physical therapy. The need for custodial care (for example, assistance with activities of daily living, like bathing and dressing) cannot, in itself, qualify you for Medicare coverage in a skilled nursing facility. However, if you qualify for coverage based on your need for skilled nursing or rehabilitation, Medicare will cover all of your care needs in the facility, including assistance with activities of daily living.

SNF COINSURANCE

For the 21th through 100th day of extended care services in a benefit period, a daily amount for which the beneficiary is responsible, equal to one-eighth of the inpatient hospital deductible.

SPECIAL ELECTION PERIOD

A set time that a beneficiary can change health plans or return to the Original Medicare Plan, such as: you move outside the service area, your Medicare Advantage organization violates its contract with CMS, or other exceptional conditions determined by CMS. The Special Election Period is different from the Special Enrollment Period (SEP). (See Election Periods; Enrollment; Special Enrollment Period (SEP).)

SPECIALIST

A doctor who teats only certain parts of the body, certain health problems, or certain age groups. For example, some doctors treat only heart problems.

SPECIALTY PLAN

A type of Medicare Advantage Plan that provides more focused health care for some people. These plans give you all your Medicare health care as well as more focused care to manage a disease or condition such as congestive heart failure, diabetes, or End-Stage-Renal Disease.

SPECIFIED DISEASE INSURANCE
This kind of insurance pays benefits for only a single disease, such as cancer, or for a group of diseases. Specified Disease Insurance doesn't fill gaps in your Medicare coverage.

SPECIFIED LOW-INCOME MEDICARE BENEFICIARIES (SLMB)
A Medicaid program that pays for Medicare Part B premiums for individuals who have Medicare Part A, a low monthly income, and limited resources.

SPEECH-LANGUAGE THERAPY
Treatment to regain and strengthen speech skills.

STATE INSURANCE DEPARTMENT
A state agency that regulates insurance and can provide information about Medigap policies and any insurance related problem.

STATE OR LOCAL PUBLIC HEALTH CLINIC
A facility maintained by either State or local health departments that provide ambulatory primary medical care under the general direction of a physician.

SUBSIDIZED SENIOR HOUSING
A type of program, available through the Federal Department of Housing and Urban Development and some States, to help people with low or moderate incomes pay for housing.

SUPLEMENTARY MEDICAL INSURANCE
The Medicare program that pays for a portion of the costs of physicians' services, outpatient hospital services, and other related medical and health services for voluntarily insured aged and disabled individuals. Also known as Part B.

SUPPLIER
Generally, any company, person, or agency that gives you a medical item or service, like a wheelchair or walker.

TERM INSURANCE
A type of insurance that is in force for a specified period of time.

THIRD PARTY ADMNISTRATOR
An entity required to make or responsible for making payment on behalf of a group health plan.

TRANSIENT PATIENTS
Patient who receive treatments on an episodic basis and are not part of a facilities regular caseload (i.e. patients who have not been permanently transferred to a facility for ongoing treatments).

TREATMENT
Something done to help with a health problem. For example, medicine and surgery are treatments.

TREATMENT OPTIONS
The choices you may have to treat your health problem.

TRICARE
A health care program for active duty and retired uniformed services members and their families.

TRICARE FOR LIFE (TFL)
Expanded medical coverage available to Medicare-eligible uniformed services retirees age 65 or older, their eligible family members and survivors, and certain former spouses.

TTY
A teletypewriter (TTY) is a communication device used by people who are deaf, hard of hearing, or have a severe speech impairment. TTY consists of a keyboard, display screen, and modem. Messages travel over regular telephone lines. People who don't have a TTY can communicate with a TTY user through a message relay center (MRC). An MRC has TTY operators available to send and interpret TTY messages.

UNASSIGNED CLAIM
A claim submitted for a service or supply by a provider who does not accept assignment.

URGENTLY NEEDED CARE
Care that you get for a sudden illness or injury that needs medical care right away, but is not life threatening. Your primary care doctor generally provides urgently needed care if you are in a Medicare health plan other than the Original Medicare Plan. If you are out of your plan's service area for a short time and cannot wait until you return home, the health plan must pay for urgently needed care.

VOCATIONAL REHABILITATION
The process of facilitating an individual in the choice of or return to a suitable vocation. When necessary, assisting the patient to obtain training for such a vocation. Vocational rehabilitation can also mean to preparing an individual regardless of age, status (whether U.S. citizen or immigrant) or physical condition (disability other than ESRD) to cope emotionally, psychologically, and physically with changing circumstances in life, including remaining at school or returning to school, work, or work equivalent (homemaker).

WAITING PERIOD
The time between when you sign up with a Medigap insurance company or Medicare health plan and when the coverage starts.

WORKERS COMPENSATION
Insurance that employers are required to have to cover employees who get sick or injured on the job.